Filing at a Glance

Company:	Cigna Health and Life Insurance Company
Product Name:	2016 Regulatory Filing
State:	District of Columbia
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.002C Large Group Only - Other
Filing Type:	Form
Date Submitted:	11/07/2016
SERFF Tr Num:	CCGH-130795901
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	HC-SOC567
Implementation Date Requested:	On Approval
Author(s):	Janet Stone, Karen Montanaro, Eva Midgley
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Trust
Filing Status Changed: 11/10/2016
State Status Changed:
Created By: Karen Montanaro
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Karen Montanaro

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
November 4, 2016

Re:Cigna Health and Life Insurance Company
NAIC Company ID#: 67369
NAIC Group #: 901
FEIN: 59-1031071
Group Accident and Health Insurance
Policy/Certificate Series HP/HC
Certificate Insert Page: HC-SOC567 et al

Dear Sir or Madame:
We are submitting for your approval the above-referenced Group Accident and Health certificate insert pages to be used with our combined Policy/Certificate Document previously approved by your Department on 08/09/2010 in SERFF filing CCGH-126618547.

We are filing certificate insert pages which include:
•Pharmacy Schedule, Benefit Provisions, Important Information Provisions and Definitions,
•Prior Authorization
•Medical Covered Expense
•Definition of Medically Necessary,
•Medical Benefit Schedule,
•Exclusions,
•Coordination of Benefits,
•Subrogation,
•Payment of Benefits,
•Appointment of Authorized Representative and
•Definition of Dependent.

State: District of Columbia **Filing Company:** Cigna Health and Life Insurance Company
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We consider any bracketed areas to be variable as shown. Please find the enclosed Description of Variable Material. The rate information for these benefits is included in the Rate filing approved on 10/18/16 under SERFF Tracking Number: CCGP – 130666805.

This submission does not replace any certificate insert pages on file with your Department.

We have attached redlines showing changes to previously approved forms under the Supporting Documentation tab.

Thank you very much for your attention to this submission. If you have any questions or concerns, you can contact me directly at 860.226.5631. I can also be reached via e-mail at karen.montanaro@cigna.com.

Sincerely,

Karen Montanaro

Company and Contact

Filing Contact Information

Karen Montanaro, Compliance Specialist
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Hartford, CT 06152

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Filing Company Information

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, CT 06002
(860) 226-6000 ext. [Phone]

CoCode: 67369
Group Code: 901
Group Name:
FEIN Number: 59-1031071

State of Domicile: Connecticut
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

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Form Schedule

Lead Form Number: HC-SOC567

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		The Schedule Pharmacy	HC-SOC567	SCH	Initial		45.200	HC-SOC567 RX Schedule (3).pdf
2		The Schedule Medical	HC-SOC568	SCH	Initial		45.200	HC-SOC568 Med Sch.pdf
3		Important Information – Rebates and Other Payment	HC-IMP188	CERA	Initial		45.200	HC-IMP188 Rebates & Coupons.pdf
4		Prior Authorization/Pre-Authorized	HC-PRA26	CERA	Initial		45.200	HC-PRA26 Prior Auth.pdf
5		Covered Expenses-Medical Pharmaceuticals	HC-COV526	CERA	Initial		45.200	HC-COV526 Medical Pharmaceutical.pdf
6		Prescription Drug Benefits - Covered Expenses	HC-PHR136	CERA	Initial		45.200	HC-PHR136 RX Covered Expenses.pdf
7		Prescription Drug Benefits - Limitations	HC-PHR137	CERA	Initial		45.200	HC-PHR137 RX Limitations (4).pdf
8		Prescription Drug Benefits - Your Payments	HC-PHR138	CERA	Initial		45.200	HC-PHR138 RX Your Payments.pdf
9		Prescription Drug Benefits - Exclusions	HC-PHR139	CERA	Initial		45.200	HC-PHR139 RX Exclusions.pdf
10		Prescription Drug Benefits - Reimbursement	HC-PHR140	CERA	Initial		45.200	HC-PHR140 RX Reimbursement.pdf
11		Exclusions	HC-EXC234	CERA	Initial		45.200	HC-EXC234 Exclusions.pdf
12		Expenses For Which A Third Party May Be Responsible	HC-SUB77	CERA	Initial		45.200	HC-SUB77.pdf
13		Expenses For Which A Third Party May Be Responsible	HC-SUB78	CERA	Initial		45.200	HC-SUB78.pdf

SERFF Tracking #: CCGH-130795901 **State Tracking #:** **Company Tracking #:** HC-SOC567

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Project Name/Number: /

Lead Form Number: HC-SOC567

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
14		Coordination of Benefits	HC-COB135	CERA	Initial		45.200	HC-COB135.pdf
15		Payment of Benefits	HC-POB89	CERA	Initial		45.200	HC-POB89.pdf
16		Appointment of Authorized Representative	HC-AAR1	CERA	Initial		45.200	HC-AAR Apt of Auth Rep.pdf
17		Definition-Biologic	HC-DFS840	CERA	Initial		45.200	HC-DFS840 Biologic.pdf
18		Definition- Biosimilar	HC-DFS841	CERA	Initial		45.200	HC-DFS841 Biosimilar.pdf
19		Definition- Brand Drug	HC-DFS842	CERA	Initial		45.200	HC-DFS842 Brand Drug.pdf
20		Definition- Business Decision Team	HC-DFS843	CERA	Initial		45.200	HC-DFS843 Business Decision Team.pdf
21		Definition-Cigna Home Delivery Pharmacy	HC-DFS844	CERA	Initial		45.200	HC-DFS844 Cigna HD Pharmacy.pdf
22		Definition-Dependent	HC-DFS877	CER	Initial		45.200	HC-DFS877 Definition of Dependent.pdf
23		Definition-Designated Pharmacy	HC-DFS845	CERA	Initial		45.200	HC-DFS845 Designated Pharmacy.pdf
24		Definition-Generic Drug	HC-DFS846	CERA	Initial		45.200	HC-DFS846 Generic Drug.pdf
25		Definition-Maintenance Drug Product	HC-DFS847	CERA	Initial		45.200	HC-DFS847 Maintenance Drug Product.pdf
26		Definition-Medical Pharmaceutical	HC-DFS848	CERA	Initial		45.200	HC-DFS848 Medical Pharmaceutical.pdf
27		Definition-Network Pharmacy	HC-DFS849	CERA	Initial		45.200	HC-DFS849 Network Pharmacy.pdf

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Lead Form Number: HC-SOC567

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
28		Definition-New Prescription Drug Product	HC-DFS850	CERA	Initial		45.200	HC-DFS850 New Prescription Drug Product.pdf
29		Definition-Pharmacy	HC-DFS851	CERA	Initial		45.200	HC-DFS851 Pharmacy.pdf
30		Definition- P & T Committee	HC-DFS852	CERA	Initial		45.200	HC-DFS852 P & T Committee.pdf
31		Definition- Prescription Drug Charge	HC-DFS853	CERA	Initial		45.200	HC-DFS853 Prescription Drug Charge.pdf
32		Definition- Prescription Drug List	HC-DFS854	CERA	Initial		45.200	HC-DFS854 Prescription Drug List (2).pdf
33		Definition- Prescription Drug Product	HC-DFS855	CERA	Initial		45.200	HC-DFS855 Prescription Drug Product.pdf
34		Definition- Prescription Order or Refill	HC-DFS856	CERA	Initial		45.200	HC-DFS856 Prescription Order or Refill.pdf
35		Definition- Preventive Care Medications	HC-DFS857	CERA	Initial		45.200	HC-DFS857 Preventive Care Medications.pdf
36		Definition-Specialty Prescription Drug Product	HC-DFS858	CERA	Initial		45.200	HC-DFS858 Specialty PD Product (2).pdf
37		Definition-Therapeutic Alternative	HC-DFS859	CERA	Initial		45.200	HC-DFS859 Therapeutic Alternative.pdf
38		Definition-Therapeutic Alternative	HC-DFS860	CERA	Initial		45.200	HC-DFS860 Therapeutic Equivalent.pdf
39		Definition- Usual & Customary Charge	HC-DFS861	CERA	Initial		45.200	HC-DFS861 U & C Charge.pdf
40		Definition- Non-PPACA Preventive Medicine	HC-DFS864	CERA	Initial		45.200	HC-DFS864 NPPACA Preventive Med.pdf

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Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
41		Definition- Preventive Medication	HC-DFS873	CERA	Initial		45.200	HC-DFS873 Preventive Medication.pdf
42		Definition- Medically Necessary	HC-DFS876	CERA	Initial		45.200	HC-DFS876 Medically Necessary.pdf
43		Covered Expenses	HC-COV534	CERA	Initial		45.200	HC-COV534 Covered Expenses.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Prescription Drug Benefits
The Schedule

For You [and Your Dependents] *Remove variable text for Employee only plans.*

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you [and your Dependents] may be required to pay a portion of the Covered Expenses for Prescription Drug Products. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Include variable text as applicable.
As applicable, your Deductible or Coinsurance payment will be based on [the Prescription Drug Charge when the Pharmacy is a Network Pharmacy][, and the Usual and Customary Charge when the Pharmacy is a non-Network Pharmacy].

Add text for plans when member pays 100% of the discounted cost. Remove variable text for Employee only plans.
[You [and your Dependents] will pay 100% of the Prescription Drug Charge at a Network Pharmacy for Prescription Drugs Products that are excluded under this plan.]

Remove the Coinsurance paragraph for a copay only plan design. Remove variable text for Employee only plans.

[Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drug Products that you [or your Dependent] are required to pay under this plan.]

Include variable text when non-Network Pharmacies are covered.

Charges

The term Charges means the Prescription Drug Charge when the Pharmacy is a Network Pharmacy[, and it means the Usual and Customary Charge when the Pharmacy is a non-Network Pharmacy].

Include the following for plans with Copayment feature. Remove variable text for Employee only plans.

[Copayments (Copay)

Copayments are expenses to be paid by you [or your Dependent] for Covered Prescription Drug Products.]

***PPCA exempt**: Use the following if an annual maximum is elected otherwise delete. Remove for PPACA compliant plans.*

[Annual Maximum

The total amount of Prescription Drug benefits payable for all expenses incurred at a Pharmacy in a [contract][calendar] year will not exceed the Annual Maximums shown in The Schedule.]

Use the following when client elects pharmacy deductibles otherwise delete. Do not use with Collective or Combined Deductible option. Remove variable text for Employee only plans.

[**[Contract] [Calendar] Year Deductible**

Deductibles are expenses to be paid by you [or your Dependent] for Covered Prescription Drug Products. These Deductibles are in addition to any Copayments or Coinsurance. Once the Deductible maximum shown in The Schedule has been reached you [and your family] need not satisfy any further Prescription Drug Deductible for the rest of that year.]

Include the following paragraph when client elects pharmacy out-of-pocket maximums otherwise delete. Do not use with Collective or Combined OOP option. Include the variable text items when applicable to the OOP maximum due to PPACA or client election.

[Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drug Products for which no payment is provided because of the Coinsurance factor [and any [Copayments] [or] [Deductibles]]. When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.]

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Participating Pharmacies at 100% [after deductible] [with no deductible] and if applicable at Non-Participating Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
***PPCA exempt**: Use with Combined Med Pharm benefit for PPCA exempt.*		
[Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule]
***PPCA exempt**: Use the following boxes for separate lifetime maximum for PPCA exempt.*		
[Lifetime Maximum	[$10,000-Unlimited]	[$10,000-Unlimited]]
***PPCA exempt**: Use the following box for PPCA exempt if an annual maximum is elected. Modify for client elect benefits. If no annual maximum is elected omit the box.*		
[Annual Maximum Individual Annual Maximum	*Modify based on account specifics* [$[0-5,000] per person] [Not Applicable]	*Modify based on account specifics* [$[0-5,000] per person] [Not Applicable]
Family Annual Maximum	*Modify based on account specifics* [$[0-15,000] per family] [Not Applicable]	*Modify based on account specifics* [$[0-15,000] per family] [Not Applicable]]
***Pharmacy Deductible:** Use the following when pharmacy deductibles are elected but NOT Combined with medical or Collective. Modify for client elect benefits. If a deductible is not elected delete the box.*		
[[Contract] [Calendar] Year Deductible[*] Individual	*Modify based on account specifics* [$[0-700] per person] [Not Applicable]	*Modify based on account specifics* [$[0-10,000] per person] [Not Applicable]
Family	*Modify based on account specifics* [$[0-2,100] per family] [Not Applicable]	*Modify based on account specifics* [$[0-30,000] per family] [Not Applicable]]
***Combined MED/PHARM Deductible or Collective Deductible:** Use the following box if Combined MED/PHARM deductible or Collective Deductible. Otherwise delete.*		
[[Contract] [Calendar] Year Deductible[*] Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule]
***Deductible Option for Generic Drugs:** Use the following box immediately after the deductible box for accounts that have elected to waive the deductible for generic drugs.*		
[*Note: [Preferred] Generic Drugs [and] [,Non-Preferred Brand Drugs] [,Preferred Brand		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Drugs] at a [retail] [Designated] [or] [home delivery] [Network] Pharmacy are not subject to the Deductible.]		
Preventive Drug Option: *Use the following box immediately after the deductible box for plans that exclude the Preventive Drugs from the deductible, copay or coinsurance.* *Remove text for grandfathered and exempt plans that do not elect to cover preventive medications at 100%. If they do elect to cover preventive medications at 100%, then remove "Non-PPACA".*		
[[*] [Non-PPACA] Preventive Medications [Generic] [or] [preferred Brand] [Non-PPACA] Preventive Medications used to prevent any of the following medical conditions and that are dispensed by a [retail][or] [home delivery] [Network] Pharmacy are not subject to [the Deductible] [and] [Copay] [and] [Coinsurance]: • [hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency] *Include if additional medications are elected by the group* • [nutrient deficiency] • [smoking cessation] • [antiobesity and weight loss]]		
Out-of-Pocket Expenses: *Use the following when pharmacy out-of-pocket maximums are elected but NOT Combined with medical or collective. Modify for client elect benefits. If a pharmacy OOP maximum is not elected delete.*		
[Out-of-Pocket Maximum Individual	*Modify based on account specifics* *Note: for 2016 Non-grandfathered plans per person* [$[0-$6,850] per person], *indexed annually* *grandfathered and exempt plans* [$[0-10,000] per person] [Not Applicable]	*Modify based on account specifics* [$[0-10,000] per person] [Not Applicable]
Family	*Modify based on account specifics* Note: for 2016 Non grandfathered with Collective Out-of-Pocket Maximum [$[0-6,850] indexed annually *Note: for 2016 Non-grandfathered plans with Individual calculation Out-of-Pocket Maximum* [$[0-13,700] per family] *indexed annually* *grandfathered and exempt plans* [$[0-30,000] per family] [Not Applicable]	*Modify based on account specifics* [$[0-30,000] per family] [Not Applicable]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Combined MED/PHARM OOP Maximum: *Use the following box if Combined MED/PHARM OOP Maximum or collective. Otherwise delete.*		
[Out-of-Pocket Maximum Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule]
Mandatory 90-102 day Maintenance Drugs: *Add text for clients that elect the Mandatory 90-102 day Maintenance option.* • *Select supply amount within the range shown.* • *Select "Designated" for Mandatory 90-102 with a limited 90-102 day retail network otherwise delete.* • *Select "Network "for all other networks.* • *Do not select "Network" or "Designated" if the client has out-of-network coverage.* • *Select number of fills based on client election.* • *Include reference to home delivery Pharmacy when home delivery coverage is elected.*		
[Maintenance Drug Products Maintenance Drug Products must be filled in an amount equal to a consecutive [90-102] day supply per Prescription Order or Refill at a retail [Designated] [Network] Pharmacy [or home delivery[Network] Pharmacy], after [1, 2, 3] [30-34] day supply fill[s] at a retail [Network] Pharmacy [or home delivery [Network] Pharmacy]. If you do not fill your Maintenance Drug Products in a [90-102] day supply at a retail [Designated] [Network] Pharmacy [or home delivery [Network] Pharmacy] after the specified [30-34] day supply fill limit, the Plan will not cover the Maintenance Drug Product.]		
Voluntary 90-102 day Maintenance Drugs: *Add text for clients that elect the Voluntary 90-102 day Maintenance option.* • *Select supply amount within the range shown..* • *Select "Designated" for Maintenance 90-102 with the limited 90-102 day retail network, otherwise delete.* • *Select "Network "for all other networks.* • *Do not select "Network" or "Designated" if the client has out-of-network coverage.* • *Include reference to home delivery Pharmacy when home delivery coverage is elected.*		
[Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive [90-102] day supply per Prescription Order or Refill at a retail [Designated] [Network] Pharmacy [or home delivery [Network] Pharmacy].]		
Remove text based on client election for plans that are not subject to PPACA. Add note when contraceptives are not covered at 100%. [Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a [home delivery] [Network] Pharmacy. A written prescription is required.] [Note: Contraceptive devices and oral contraceptives are payable as shown in the Schedule.]		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
Retail Drugs-30-34 day supply: *Select the option that matches the client elect benefits and vary as shown. Select the supply limit within the range shown.*		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive [30-34] day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive [30-34] day supply at a non-Network Pharmacy**
Include with Specialty Exclusive home delivery option.		
[Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy[, after [1, 2, 3] fill[s] of the Specialty Prescription Drug Product at a retail Pharmacy].]		
Remove for 1 tier plans **[Tier 1]**		
Use with a 1 tier plan [Generic Drugs and Brand Drugs] *Use with a 2 Tier plan design* [Generic Drugs] *Use one of the following with a 3 Tier or 4 Tier plan design* *Option 1* [Generic Drugs on the Prescription Drug List] *Option 2* **[**Generic Drugs designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* **[**Generic Drugs designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 4* [Preferred Generic Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 1 on the Prescription Drug List]	*Include this text piece only with Mandatory 90-102 day otherwise omit.* [Non-Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-30] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-30], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-30],] [and] [a maximum of $[0-30],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] *Include this text piece with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Non-Maintenance Drug Products:] *Include for OON coverage* [[0-70]%] [after [pharmacy] [plan] Deductible]]
Include text options below if Mandatory 90-102 day is elected, otherwise omit. Select the supply limit within the range shown.		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
	[Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-30] copay][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans* [[0-50]%,][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-30], then the plan pays 100%][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-30],] [and] [a maximum of $[0-30],] then the plan pays 100%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]	*Include text options that follow with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Maintenance Drug Products:] [[0-70]%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]
[Tier 2		
Use the following with a 2 Tier plan design: [Brand Drugs] *Use one of the following with a 3 Tier or 4 Tier plan design:* *Option 1* [Brand Drugs designated as preferred on the Prescription Drug List]	*Include this text piece only with Mandatory 90-102 day otherwise omit.* [Non-Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-80] copay] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] *Include this text piece with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Non-Maintenance Drug Products:]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
Option 2 [Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* [Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List and Brand Drugs designated as preferred on the Prescription Drug List] *Option 4* [Preferred Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 2 on the Prescription Drug List]	*Use for coinsurance plans* [[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-80], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-80],] [and] [a maximum of $[0-80],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	[[0-70]%] [after [pharmacy] [plan] Deductible]]
Include text options below if Mandatory 90-102 day is elected, otherwise omit. Select the supply limit within the range shown.		
	[Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-80] copay][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans* [[0-50]%,][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-80], then the plan pays 100%][after [pharmacy] [plan]	*Include text options that follow with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Maintenance Drug Products:] [[0-70]%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] [30-34] day supply]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
	Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-80],] [and] [a maximum of $[0-80],] then the plan pays 100%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]	
[Tier 3		
Use one of the following with a 3 Tier or 4 Tier plan design: *Option 1* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Options 2* **[**Brand Drugs designated as preferred on the Prescription Drug List**]** *Options 3* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Option 4* [Non-Preferred Generic Drugs and Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 3 on the Prescription Drug List]	*Include this text piece only with Mandatory 90-102 day otherwise omit.* [Non-Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-120] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-70]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-70]% or $[0-120], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-70]%, subject to a [minimum of $[0-120],] [and] [a maximum of $[0-120],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] *Include this text piece with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Non-Maintenance Drug Products:] [[0-70]%] [after [pharmacy] [plan] Deductible]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
Include text options below if Mandatory 90-102 day is elected, otherwise omit. Select the supply limit within the range shown.		
	[Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-120] copay][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans* [[0-70]%,][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for "Greater of" plans* [The greater of [0-70]% or $[0-120], then the plan pays 100%][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans with a minimum and/or maximum* [[0-70]%, subject to a [minimum of $[0-120],] [and] [a maximum of $[0-120],] then the plan pays 100%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]	*Include text options that follow with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Maintenance Drug Products:] [[0-70]%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
[Tier 4		
Use 1 of the following with a 4 tier plan design *Option 1* [Self-Administered Injectable Specialty Prescription Drug Products] *Option 1, 2, or 3* [Specialty Prescription Drug Products] *Option 4* [Specialty Prescription Drug Products on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 4 on the Prescription Drug List]	*Include this text piece only with Mandatory 90-102 day otherwise omit.* [Non-Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-300] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-90]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-90]% or $[0-300], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-90]%, subject to a [minimum of $[0-300],] [and] [a maximum of $[0-300],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] *Include this text piece with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Non-Maintenance Drug Products:] [[0-90]%] [after [pharmacy] [plan] Deductible]]
Include text options below if Mandatory 90-102 day is elected, otherwise omit. Select the supply limit within the range shown.		
	[Maintenance Drug Products:] *Use for copay plans* [No charge after $[0-300] copay][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans* [[0-90]%,][after [pharmacy] [plan] Deductible] for the first	*Include text options that follow with Mandatory 90-102 day when OON coverage is elected, otherwise omit.* [Maintenance Drug Products:] [[0-90]%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	Non-NETWORK PHARMACY
	[1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for "Greater of" plans* [The greater of [0-90]% or $[0-300], then the plan pays 100%][after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply] *Use for coinsurance plans with a minimum and/or maximum* [[0-90]%, subject to a [minimum of $[0-300],] [and] [a maximum of $[0-300],] then the plan pays 100%] [after [pharmacy] [plan] Deductible] for the first [1, 2, 3] fills, then no coverage for a [30-34] day supply]	

Include the following heading and text boxes that follow as applicable, with 90-102 day Maintenance Drugs. Select the option that matches the client elect benefits.

- *Select the supply limit within the range shown.*
- *Include reference to "Designated Pharmacies" in the heading with the limited 90-102 day retail network.*
- *Select "Network " in the heading for all other networks.*

[Prescription Drug Products at Retail [Designated] Pharmacies	**The amount you pay for up to a consecutive [90-102] day supply at a [Designated] [Network] Pharmacy**	**The amount you pay for up to a consecutive [90-102] day supply at a non-[Designated] [Network] Pharmacy**

Include with Specialty Exclusive home delivery.

[Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery [Network] Pharmacy[, after [1, 2, 3] fill[s] of the Specialty Prescription Drug Product at a retail Pharmacy].]

Include with Specialty 30-34 day supply. Select the supply limit within the range shown.

[Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.]

Include with a limited 90-102 day retail network, otherwise delete. Select the supply limit within the range shown.

[Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in [90-102] day supplies per Prescription Order or Refill.]

Remove for 1 tier plans [**Tier 1]**		
Use with 1 tier plan design [Generic Drugs and Brand Drugs] *Use the following with a 2 Tier plan design:* [Generic Drugs] *Use one of the following with a 3 Tier or 4 Tier plan design* *Option 1* [Generic Drugs on the Prescription Drug List] *Option 2* **[**Generic Drugs designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* **[**Generic Drugs designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 4* [Preferred Generic Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 1 on the Prescription Drug List]	*Use for copay plans* [No charge after $[0-90] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-90], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-90],] [and] [a maximum of $[0-90],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] *Include for OON coverage* [[0-70]%] [after [pharmacy] [plan] Deductible]]
[Tier 2		
Use the following with a Tier 2 plan design: [Brand Drugs] *Use one of the following with 3 Tier or 4 Tier plan designs:* *Option 1* [Brand Drugs designated as	*Use for copay plans* [No charge after $[0-240] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans*	*Modify based on account specifics* [In-network coverage only] [[0-70]%] [after [pharmacy] [plan] Deductible]]]

preferred on the Prescription Drug List] *Option 2* **[**Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* **[**Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List and Brand Drugs designated as preferred on the Prescription Drug List] *Option 4* [Preferred Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 2 on the Prescription Drug List]	[[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-240], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-240],] [and] [a maximum of $[0-240],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	
[Tier 3		
Use one of the following with Tier 3 or Tier 4 plan designs: *Option 1* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Option 2* **[**Brand Drugs designated as preferred on the Prescription Drug List**]** *Options 3* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Option 4* [Non-Preferred Generic	*Use for copay plans* [No charge after $[0-360] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-70]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-70]% or $[0-360], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-70]%, subject to a [minimum of $[0-360],] [and]	*Modify based on account specifics* [In-network coverage only] [[0-70]%] [after [pharmacy] [plan] Deductible]]]

Drugs and Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 3 on the Prescription Drug List]	[a maximum of $[0-360],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	
[Tier 4		
       Use 1 of the following with a 4 tier plan design *Option 1* [Self-Administered Injectable Specialty Prescription Drug Products] *Option 1, 2, or 3* [Specialty Prescription Drug Products] *Option 4* [Specialty Prescription Drug Products on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 4 on the Prescription Drug List]	*Include with Specialty 30-34 day supply. Select the supply limit within the range shown.* [Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.] *Use for copay plans* [No charge after $[0-900] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-90]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-90]% or $[0-900], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-90]%, subject to a [minimum of $[0-900],] [and] [a maximum of $[0-900],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Include with Specialty 30-34 day supply. Select the supply limit within the range shown.* [Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.] *Modify based on account specifics* [In-network coverage only] [[0-90]%] [after [pharmacy] [plan] Deductible]]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Mail Order Drug: *Include the following Heading and the text boxes that follow as applicable with MOD. Select the option that matches the client elect benefits. Omit if MOD is not elected. Select the supply limit within the range shown.*		
[Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive [90-102] day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive [90-102] day supply at a non-Network Pharmacy**
Include with Specialty 30-34 day supply and modify based on client elect benefits. Select the supply limit within the range shown.		
[Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.] [and are subject to the same Copayment or Coinsurance that applies to retail [Network] Pharmacies.] *Include either option for copay plans if applicable.* [If a home delivery Pharmacy dispenses a supply of [30-34] days or less of your Prescription Drug Product (including a Specialty Prescription Drug Product), the home delivery Pharmacy Copayment [will be prorated to reflect a [30-34] day supply.][will reflect the same Copayment or Coinsurance that applies to retail [Network][Pharmacies]. [[If a [home delivery] Pharmacy dispenses a supply of less than [30-34] days of your Prescription Drug Product (including a Specialty Prescription Drug Product), the [home delivery] Pharmacy Copayment will be adjusted to reflect the specific days' supply dispensed.]		
Remove for 1 tier plans. **[Tier 1]** *Use with a 1 tier plan* [Generic Drugs and Brand Drugs] *Use with a 2 Tier plan design* [Generic Drugs] *Use one of the following with a 3 Tier or 4 Tier plan design* *Option 1* [Generic Drugs on the Prescription Drug List] *Option 2* **[**Generic Drugs designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* **[**Generic Drugs designated as Non-PPACA Preventive	*Use for copay plans* [No charge after $[0-90] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-90], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-90],] [and] [a maximum of $[0-90],] then the	*Modify based on account specifics* [In-network coverage only] [[0-70]%] [after [pharmacy] [plan] Deductible]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Medications on the Prescription Drug List] *Option 4* [Preferred Generic Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 1 on the Prescription Drug List]	plan pays 100%] [after [pharmacy] [plan] Deductible]]	
[Tier 2		
Use the following with a 2 Tier plan design: [Brand Drugs] *Use one of the following with 3 Tier or 4 Tier plan design:* *Option 1* [Brand Drugs designated as preferred on the Prescription Drug List] *Option 2* **[**Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List] *Option 3* **[**Generic Drugs not designated as Non-PPACA Preventive Medications on the Prescription Drug List and Brand Drugs designated as preferred on the Prescription Drug List] *Option 4* [Preferred Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 2 on the Prescription Drug List]	*Use for copay plans* [No charge after $[0-240] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-50]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-50]% or $[0-240], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-50]%, subject to a [minimum of $[0-240],] [and] [a maximum of $[0-240],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] [[0-70]%] [after [pharmacy] [plan] Deductible]]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
[Tier 3		
Use one of the following with 3 Tier or 4 Tier plan design: *Option 1* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Option 2* **[**Brand Drugs designated as preferred on the Prescription Drug List**]** *Options 3* [Brand Drugs designated as non-preferred on the Prescription Drug List] *Option 4* [Non-Preferred Generic Drugs and Brand Drugs on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 3 on the Prescription Drug List]	*Use for copay plans* [No charge after $[0-360] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-70]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-70]% or $[0-360], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-70]%, subject to a [minimum of $[0-360],] [and] [a maximum of $[0-360],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Modify based on account specifics* [In-network coverage only] [[0-70]%] [after [pharmacy] [plan] Deductible]]]

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
[Tier 4		
Use 1 of the following with a 4 tier plan design *Option 1* [Self-Administered Injectable Specialty Prescription Drug Products] *Option 1, 2, or 3* [Specialty Prescription Drug Products] *Option 4* [Specialty Prescription Drug Products on the Prescription Drug List] *Option 5* [Prescription Drug Products designated as Tier 4 on the Prescription Drug List]	*Include with Specialty 30-34 day supply. Select the supply limit within the range shown.* [Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.] *Use for copay plans* [No charge after $[0-900] copay] [after [pharmacy] [plan] Deductible]] *Use for coinsurance plans* [[0-90]%] [after [pharmacy] [plan] Deductible]] *Use for "Greater of" plans* [The greater of [0-90]% or $[0-900], then the plan pays 100%][after [pharmacy] [plan] Deductible]] *Use for coinsurance plans with a minimum and/or maximum* [[0-90]%, subject to a [minimum of $[0-900],] [and] [a maximum of $[0-900],] then the plan pays 100%] [after [pharmacy] [plan] Deductible]]	*Include with Specialty 30-34 day supply. Select the supply limit within the range shown.* [Specialty Prescription Drug Products are limited to up to a consecutive [30-34] day supply per Prescription Order or Refill.] *Modify based on account specifics* [In-network coverage only] [[0-90]%] [after [pharmacy] [plan] Deductible]]]

[Plan Name] Medical Benefits

The Schedule

For You [**and Your Dependents**]

[Network] [Network Open Access] [Exclusive Provider Organization][Open Access Plus In-Network] [Comprehensive] [Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive [Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

[If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.]

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

[**Copayments/Deductibles**

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. [Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.]]

[Out of Pocket Expenses – [For In-Network Charges Only]

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.]

[Out of Pocket Expenses –[For Out-of-Network Charges Only]

The Schedule

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for [In-Network][and][Out-of-Network] charges that are not paid by the benefit plan. The following [In-Network] [and] [Out-of-Network] Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%. [Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, In-Network copayments and Out-of-Network deductibles are no longer required.]

- [Coinsurance]
- [Plan Deductible]
- [coinsurance][and][copayments][and][Per Day][deductibles]] [for the following:]
    - [inpatient hospital facility]

- [outpatient facility]
- [Advanced Radiological Imaging]
- [emergency room]
- [office visit]
- [urgent care]
- [Obesity/Bariatric [surgery] [treatment]]
- [infertility]
- [hearing aids]
- [External Prosthetic Appliances]
- [[Medical] [and] [Pharmacy] [Cigna Pharmacy][Mail Order Pharmacy]
- [Mental Health] [and] [Substance Use Disorder] [Ambulance]
- [Ambulatory Free Standing Surgical]
- [DME life sustaining]
- [Medical Supplies]
- [Acupuncture]
- [TMJ]
- [Home Health Care]
- [Hospice]
- [Outpatient Short-Term Rehabilitation]
- [Chiropractic Services]
- [Skilled Nursing]

The following Out-of-Pocket [In-Network] [and] [Out-of-Network] Expenses and charges do not contribute to the Out-of-Pocket Maximum and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached.

- [non-compliance penalties]

If exempt from MHPA

- [Out-of-Network Outpatient [Mental Health] [and Substance Use Disorder treatment]]
- [provider charges in excess of the Maximum Reimbursable Charge]
- [Coinsurance]
- [Plan Deductible]
- [coinsurance][and][copayments][and][deductibles] [for the following:]
    - [inpatient hospital facility]
    - [outpatient facility]
    - [Advanced Radiological Imaging]

- [emergency room]
- [office visit]
- [urgent care]
- [Obesity/Bariatric [surgery] [treatment]]
- [infertility]
- [hearing aids]
- [External Prosthetic Appliances]
- [[Medical] [and] [Pharmacy] [Cigna Pharmacy][Mail Order Pharmacy]
- [Mental Health] [and] [Substance Use Disorder]
- [Lab and X-ray]
- [Ambulance]
- [Ambulatory Free Standing Surgical]
- [DME life sustaining]
- [Medical Supplies]
- [Acupuncture]
- [TMJ]
- [Home Health Care]
- [Hospice]
- [Outpatient Short-Term Rehabilitation]
- [Chiropractic Services]
- [Skilled Nursing]]

[**Note:**
For information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan, refer to **What You Should Know about Cigna Choice Fund**.]

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

[Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, [Out-of-Network will accumulate to In-Network] [In-Network will accumulate to Out-of-Network]). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]

[Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). However, all other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[Accumulation of Pharmacy Benefits

If your plan provides Pharmacy benefits separately, any [In-Network] medical Out-of-Pocket Maximums will cross accumulate with any [In-Network] Pharmacy Out-of-Pocket Maximums.]

[**Contract Year**

Contract Year means a twelve month period beginning on each [Month] [Date].]

[**Guest Privileges**

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.]

[**Assistant Surgeon and Co-Surgeon Charges**

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.]

[Out-of-Network Emergency Services Charges]

1 [Emergency services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.]

2 [The allowable amount used in determining benefit payments for emergency services provided in the emergency department of a non-participating (Out-of-Network) Hospital is the greatest of the following: (i) the median amount negotiated with In-Network providers for the emergency service (excluding In-Network copay or coinsurance); (ii) the Maximum Reimbursable Charge, or (iii) the amount payable under the Medicare program (not to exceed the provider's billed charges).]

3 [The allowable amount used in determining benefit payments when Out-of-Network Emergency services result in an inpatient admission is the median amount negotiated with In-Network facilities.]

[The member is responsible for the applicable In-Network cost-sharing amounts, plus all charges in excess of the allowable amount set forth in #2 and [#3] above.]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Lifetime Maximum for essential benefits	Unlimited] [10,000-Unlimited]**	
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]	[$10,000-Unlimited]]
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for non-essential benefits**	[Not Applicable] [$10,000-Unlimited]	[$10,000-Unlimited]
** For use with plans exempt from PPACA only.		
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	[50-100]%	[30-80]% [of the Maximum Reimbursable Charge] [see below]
[**Maximum Reimbursable Charge** [(Maximum Reimbursable Charge limits do not apply to charges for covered Out-of-Network Emergency Services provided in an emergency department of a Hospital)] Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
• [A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.]	Not Applicable	[70-90]th Percentile]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[**Medical Charges**] [A percentage of a fee schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the [70-90]th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.] • [[0 – 60%] of the provider's normal charge (i.e., the charge made to patients without coverage) for a similar service or supply]	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[Out of Network: • [Facility Services • Professional Services/Other Services (Non-Professional & Non-Facility)] [Charges for services such as Laboratory, Radiology, Pathology and Anesthesia, that are provided by an Out-of-Network provider, in an In-Network facility, while you are receiving In-Network services at that In-Network facility are covered In-Network.] • [Facility Services • Professional Services/Other Services (Non-Professional & Non-Facility)]] (excludes Mental Health and Substance Use Disorder)		[[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge]
[**Mental Health And Substance Use Disorder** • A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.]	Not Applicable	[70-90]th Percentile]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Note: In addition to applicable deductible, co-payments and coinsurance payments, you are responsible for any charges above the Maximum Reimbursable Charge.]		
[**Automatic Reinstatement** The total amount of Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule. However, once a person uses any portion of his Maximum Benefit, on each January 1, Cigna will reinstate the used amount up to $[1,000-5,000] to be applied to Covered Expenses incurred after the date of reinstatement.]		
[[**Contract**] [**Calendar**] **Year Deductible** Individual [Applies when Employee only is covered under the plan]	[$[0-10,000] per person] [Not Applicable]	[$[0-10,000] per person] [Not Applicable]
Family Maximum	[$[0-30,000] per family] [Not Applicable]	[$[0-30,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Family Maximum Calculation **Individual Calculation** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]		
[**Combined Medical/Pharmacy** [**Contract**] [**Calendar**] **Year**		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	[No] [Yes] [No] [Yes]	[No] [Yes] [In-Network Coverage only] [No] [Yes]]
[RX cap contribution to the combined Medical/Pharmacy Deductible **Note:** Once the RX cap amount or the combined Medical/Pharmacy deductible has been met, the terms of the Pharmacy plan benefits are applicable.	$[0-900]	[In-Network Coverage only] $[0-900]]
[**Out-of-Pocket Maximum**		
Individual Individual [–Employee Only] [Individual – within a Family] [Applies when Employee only is covered under the plan]	Note: for 2016 NGF plans:[$[0-6,850] per person] [Indexed Annually] Note: for GF or Exempt plans: [$[0-30,000] per person] [Not Applicable]	[$[0-90,000] per person] [Not Applicable]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Family Maximum	Note: for 2016 NGF with Collective Out-of-Pocket Maximum [$[0-6,850] [Indexed Annually] Note: for NGF plans with Individual Calculation Out-of-Pocket Maximum: [$[0-13,700] Note: for GF or Exempt plans $[0-90,000] per family [Not Applicable]	[$[0-90,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family deductible has been satisfied.]	Note: may be used for NGF only if Out of Pocket Maximum is less than or equal to mandated self only Individual Out of Pocket Maximum.	
[Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.]		
[**Combined Medical/Pharmacy Out-of-Pocket Maximum**		
Combined Medical/Cigna Pharmacy Out-of-Pocket: includes retail and home delivery drugs	[No] [Yes]	[No] [Yes]
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	[No] [Yes]	[In-Network coverage only] [No] [Yes]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[RX cap contribution to the combined Medical/Pharmacy Out-of-Pocket maximum Once the RX cap amount has been met or the total Out of Pocket maximum has been met, the terms of the Pharmacy plan benefits are applicable and subject to: Option 1: Pharmacy paid at 100% once the cap amount has been met. Option 2: Pharmacy continued to be paid at the Pharmacy Program levels (i.e. copay, coinsurance)[until Out of Pocket Maximum is met, then at 100%]	$[0-30,000]	[In-Network coverage only] $[0-30,000]]
Physician's Services		
Primary Care Physician's Office visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2-Unlimited] [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%
Surgery Performed In the Physician's Office	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Second Opinion Consultations (provided on a voluntary basis)	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Allergy Treatment/Injections	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Allergy Serum (dispensed by the Physician in the office)	[No charge] [Primary Care Physician] [plan deductible] [then] [50-100]% [Specialty Care Physician] [plan deductible] [then] [50-100]%	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Convenience Care Clinics [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Medical Telehealth	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network Coverage Only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
THE SCHEDULE		
Preventive Care		[Unlimited] [$250-$2,000]*
	In-Network Benefits	Out of Network Benefits
[**Preventive Care** [Routine Preventive Care : Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)] [Routine Preventive Care (for children through age 20)] [Routine Preventive Care (for ages 21 and over)] [**Note:** Well-Woman OB/GYN visits will be considered a Specialist visit.] [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Preventive X-ray and/or Lab Services	[No Charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Immunizations [for children through age 20)] [for ages 21 and over)]	[No charge]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
[[**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]		
Physician's Office Visit	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [[plan deductible] [then] [30-80]%] [Specialty Care Physician] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Immunizations	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Mammograms, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible]	No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible
PSA Preventive Care Related Services (i.e. "routine" services)	[plan deductible] [then] [No Charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [No charge] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Preventive Care Related Services (i.e. "routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Mammograms and PAP Smear [Diagnostic Related Services (i.e. "non-routine" services)	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible] [No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible] [No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%
PSA [Diagnostic Related Services (i.e. "non-routine" services)	[No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%	[plan deductible] [then] [No charge] [plan deductible] [then] [30-80]%
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
	[**Note:** The associated wellness exam will be covered at no charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [**Note:** The associated wellness exam is subject to the $[0-100] PCP or $[0-150] Specialist per office visit copay]	[**Note:** The associated wellness exam is not covered]
*Variables Applicable to plans Exempt from PPACA only. Cost Share applied to In Network Benefits Applicable to Exempt and Grandfathered Plans only.		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital - Facility Services	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Semi-Private Room and Board	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Ambulatory Free Standing Surgical Centers **[for][arthroscopy]** **[colonoscopy]** **[endoscopy]**		
Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The [facility copay] [facility deductible] [facility copay or facility deductible] will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the [facility copay] [facility deductible] [facility copay or facility deductible].]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Inpatient Hospital Physician's Visits/Consultations	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Surgeon Radiologist Pathologist Anesthesiologist	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Outpatient Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Surgeon Radiologist Pathologist Anesthesiologist	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Emergency Care] [and] [Urgent Care Services]		
[If you receive Out-of-Network Emergency Services [provided in an emergency department of a Hospital] and the provider bills you for an amount higher than the amount you owe indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.]		
Urgent Care Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Urgent Care Facility or Outpatient Facility Outpatient Professional Services (radiology, pathology, and physician) X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) The scan copay/deductible applies per type of scan per day	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%] All Scan Maximums shown under Advanced Radiological Imaging MRI Per Scan Maximum apply	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]
Emergency Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Hospital Emergency Room Outpatient Professional Services (radiology, pathology, and ER physician) X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit) Independent x-ray and/or Lab Facility in conjunction with an ER visit	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) The scan copay/deductible applies per type of scan per day	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%] All Scan Maximums shown under Advanced Radiological Imaging MRI Per Scan Maximum apply	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]
Ambulance		
[Maximum not to exceed $750-75,000] [**][per][year][day][visit][trip]	[No charge[**]] [$[50-5,000] [per day][per trip] copay then[50-100]%] [[plan deductible] [then] [50-100]%] [** If not a true emergency, services are not covered]	[No charge[**]] [$[50-5,000] [per day][per trip] [copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [[3-Unlimited] days combined] [[3-Unlimited] days for Skilled Nursing Facility; [30-Unlimited] days for Rehabilitation Hospital; [30-Unlimited] days for Sub-Acute Facilities] [No prior hospitalization required]	[$[0-4,500] per day copay] [then] [No charge]] [[$[0-4,500] per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per day copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per day deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per day deductible] [then] [30-80]%] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Other Laboratory[[and] [Radiology Services:]		
Laboratory Services in a Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Laboratory Services in an Outpatient Facility [Tier 1] [Tier 2 -] [Tier 3- Out of Network]	[[plan deductible] [then] [50-100]% for facility charges; [[plan deductible] [then] [50-100]% for outpatient professional charges] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
Laboratory Services at an Independent Lab facility [Tier 1][National Lab] [Tier 2][Other Cigna Participating Lab] [Tier 3][Out of Network]	[No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Radiology Services in a Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Radiology Services at an Outpatient Facility [Tier 1] [Tier 2 -] [Tier 3- Out of Network]	[[plan deductible] [then] [50-100]% for facility charges; [[plan deductible] [then] [50-100]% for outpatient professional charges] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Advanced Radiological Imaging **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]**)** [The scan copay/deductible applies per type of scan per day] [MRI and CAT Per Scan Maximums Apply Regardless of Place of Service]		
[MRI][MRA][CAT][PET] Per Scan Maximum] [Head] [Leg] [Arm] [Abdomen] [Abdomen/Chest] [Head/Neck/Face] [Body Part] [Each Other Body Part]	 $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000]	 $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visit [MRI][CAT][PET][All other Scans]	[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-500] per scan copay] [then] [plan deductible] [then] [50-100]%] [plan deductible] [then] [50-100]% [Primary Care Physician] [[$[0-500] per scan copay] [then] [$[0-100] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [$[0-100] per office visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-500] per scan copay] [then] [$[0-150] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [$[0-150] per office visit copay] [then] [50-100]%]	[$[0-1,000] per scan deductible] then [plan deductible] [then] [30-80]%] [[plan deductible] [then][$[0-1,000] per scan deductible] [then] [30-80]%] [plan deductible] [then] [30-80]% [Primary Care Physician] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility [MRI][CAT][PET][All other Scans]	[[$[0-1,000] per scan copay] [then] [plan deductible] [then] [No charge]] [plan deductible] [then] [No charge] [[$[0-500] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-1,000] per scan deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-1,000] per scan deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
[[Habilitative Services] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [In-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [Out-of-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined]	[Primary Care Physician] [[$[0-100] per office visit copay] [but not less than $[20-150]] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per office visit copay] [but not less than $[20-150]] [then] [50-100]%] [Specialty Care Physician] [[$0-$150] [per office visit copay] [but not less than $[20-150]] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-$150] per office visit copay] [but not less than $[20-150]] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Outpatient Short-Term Rehabilitative Therapy** [**and Chiropractic Services**][and Habilitative Services] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited] [including] [for][Physical], [Speech] [and][Occupational]Therapies for treatment of [Autism][and][developmental delays][and][learning disabilities] [(The limit is not applicable to mental health conditions.)]] [In-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] [Out-of-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] Includes: [Cardiac Rehab] [Physical Therapy] [Speech Therapy] [Hearing Therapy] [Occupational Therapy] [Pulmonary Rehab] [Cognitive Therapy] [Chiropractic Therapy (includes Chiropractors)] [Physical Therapy, Speech Therapy and Occupational Therapy will not be subject to a [Contract] [Calendar] year maximum for children under age 21 with a congenital or genetic birth defect (including autism)] [The age limit does not apply to treatment for autism.]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [**Note:** The Outpatient Short Term Rehab copay [does not apply to services provided as part of a Home Health Care visit] [applies, regardless of place of service, including the home].]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Outpatient Short-Term Rehabilitative Therapy**		
[[Physical Therapy] [Speech Therapy] [Hearing Therapy] [Occupational Therapy] [Pulmonary Rehab] [and] [Cognitive Therapy]] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited] [for all therapies combined]] [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited] [for Physical, Speech and Occupational Therapies for treatment of [developmental delays][and][learning disabilities]] Physical Therapy, Speech Therapy and Occupational Therapy will not be subject to a [Contract] [Calendar] year maximum for children under age 21 with a congenital or genetic birth defect (including autism)	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
[**Outpatient Cardiac Rehabilitation** [Contract] [Calendar] Year Maximum: [36-Unlimited] days	[Specialty Care Physician] [[$[0-150] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-$150] per office visit copay] [then] [50-100]%]	[In-Network coverage only] [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[**Self-Referral**] **Chiropractic Care Services** [[Contract] [Calendar] Year Maximum: [12-Unlimited] [visits] [days] [visits or days] [consecutive days per condition] [$[500-Unlimited]] Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Home Health Care** [[Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary) [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]] [In-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary) [Administration of [Medical Specialty Drugs] [Medical Pharmaceuticals] is [40-Unlimited] [days] [visits] [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]] Out-of-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (reduced by any In-Network [days] [visits]; includes outpatient private nursing when approved as medically necessary)] [Administration of [Medical Specialty Drugs] [Medical Pharmaceuticals] is [40-Unlimited] [days] [visits] [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]]	[plan deductible] [then] [No charge] [[$[0-150]] [per visit copay] [per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150]] [per visit copay] [per day copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[**Hospice** Inpatient Services [180-Unlimited][days][visits][per Lifetime]	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Services (same coinsurance level as Home Health Care) [[3-Unlimited] [days][visits] per[Contract] [Calendar] Year	[plan deductible] [then] [No charge] [[$[0-150]] [per visit copay] [per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150]] [per visit copay] [per day copay] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Lifetime Maximum: $[5,000-Unlimited]]		
Bereavement Counseling Services Provided as part of Hospice Care		
Inpatient	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Outpatient	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Services Provided by Mental Health Professional	Covered under Mental Health benefit	[In-Network coverage only] [Covered under Mental Health benefit]
[Medical Specialty Drugs][Medical Pharmaceuticals]		
Inpatient Facility	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Physician's Office	[plan deductible] [then] 50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Home Care	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%]
Maternity Care Services		
Initial Visit to Confirm Pregnancy [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Delivery - Facility (Inpatient Hospital, Birthing Center)	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [[plan deductible] [then] [50-100]%]]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Abortion Includes [elective and] non-elective procedures		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[**Family Planning Services**		
[Physician's Office Visit (tests, counseling)] [Office Visits, Lab and Radiology Tests and Counseling] [Maximum: subject to plan's Preventive Care dollar maximum] [**Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.]	Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Surgical Sterilization Procedure for [Vasectomy][/][Tubal Ligation](excludes reversals):		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visits	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Infertility Treatment Testing and treatment for Infertility. **Note:** Medically Necessary treatment of an underlying medical condition is covered as any other illness under the plan.	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination [Services Not Covered include:] • In-vitro, GIFT, ZIFT, etc. [Surgical Treatment: Limited to procedures for the correction of infertility.]		
[Infertility Treatment Per Procedure Per Person Per Lifetime Maximums [GIFT] [ZIFT] [In Vitro]	 $[500-100,000] $[500-100,000] $[500-100,000]	 $[500-100,000] $[500-100,000] $[500-100,000]]
Physician's Office Visit (including Counseling) [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Surgical Procedure Copay] [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[[plan deductible] [then] [$[0-750] Surgical Copay]] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission][then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Lifetime Maximum: $[5,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [100% at Lifesource center, otherwise] [$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-4,500] per admission copay] [then] [100% at Lifesource center, otherwise] [plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [100% at Lifesource center , otherwise] [plan deductible] [then] [50-100]%] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]% up to transplant maximum] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]% up to transplant maximum] [[plan deductible] [then] [30-80]% up to transplant maximum]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [100% at Lifesource center , otherwise] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]% [up to specific organ transplant maximum:] Heart - $[25,000-Unlimited] Liver - $[25,000-Unlimited] Bone Marrow -$[25,000-Unlimited] Heart/Lung - $[25,000-Unlimited] Lung - $[25,000-Unlimited] Pancreas - $[25,000-Unlimited] Kidney - $[25,000-Unlimited] Kidney/Pancreas - $[25,000-Unlimited]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Lifetime] Travel Maximum: $[0-Unlimited] per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only]
[**Durable Medical Equipment (including External Prosthetic Appliances)** [In-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [[Contract] [Calendar] Year Maximum: [$500-Unlimited]] [In-Network Lifetime Maximum: $[3,000-Unlimited]] [Out-of-Network Lifetime Maximum: $[3,000-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [**Note:** Services do accumulate to the plan's out-of-pocket maximum.]	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Durable Medical Equipment** [In-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] Out-of-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] [[Contract] [Calendar] Year Maximum: $[700-Unlimited]] [**Note:** Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Nutritional Evaluation Calendar Year Maximum: 3 visits per person; however, the 3 visit limit will not apply to treatment of diabetes [and/or to Mental Health and Substance Use Disorder conditions] Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay [plan deductible] [then] [50-100]%	[plan deductible] [then] [50-100]%
[**External Prosthetic Appliances** [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [**Note:** [The EPA deductible will not accumulate to the plan Out-of-Pocket maximum.] Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [No charge]] [[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] EPA deductible per] [Contract] [Calendar]]Year] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-500] EPA deductible per] [Contract] [Calendar]]Year] [then] [30-80]%] [30-80]% [then] [plan deductible]
[Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
TMJ Surgical and Non-surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible][then] [30-80]%
[**Surgical and**] **Non-surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Obesity/Bariatric Surgery** **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [50-100]% []	[In-Network coverage only] [plan deductible] [then] [30-80]%
Lifetime Maximum: $[8,000-Unlimited] Coinsurance charges for obesity surgery will not accumulate to the plan Out-of-Pocket maximum.]		
[Dialysis Calendar Year Maximum		Maximum applies regardless of place of service $[10,000-50,000]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital - Facility Services	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The [facility copay] [facility deductible] [facility copay or facility deductible] will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the [facility copay] [facility deductible] [facility copay or facility deductible].]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Home Setting	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Hearing Exam Includes [adult hearing exams], [diagnosis][testing and fitting of hearing aid devices]	[Not Covered] [Covered the same as Specialist Office Visit]	[Not Covered] [Covered the same as Specialist Office Visit]
[Hearing Aids [1-Unlimited][Per ear][Per pair]Maximum per individual [every [1-5] years][per Lifetime] [0-115 years old] [$[500-50,000]]	[Not Covered] [plan deductible] [then] [50-100]%	[Not Covered] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
Diabetic Equipment Contract][Calendar] Year Maximum: Unlimited	[No charge] [50-100]% [after plan deductible]	[30-80]% after plan deductible]
Include for plans with no pharmacy benefit [[Diabetic Medications]	[$10] copay][	[30-80]% after plan deductible]]
[Gender Reassignment Surgery [$75,000 Lifetime Maximum across all transgender services]	[[$[0-150][then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] [then] [50-100]%]	[plan deductible] [then] [30-80]%]
[**Routine Foot Disorders**	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Routine Foot Disorders** [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited] Physician's Office Visit [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited] Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%]
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized [and will not count toward any plan limits that are shown in the Schedule for mental health and substance use disorder services including in-hospital services]. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]		
For plans <u>subject</u> to MHSUD Parity		

Inpatient Includes Acute Inpatient and Residential Treatment Unlimited maximum per Calendar year	[[[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Outpatient		
Outpatient – Office Visits Includes individual, family [and group] psychotherapy; medication management, [Behavioral Telehealth] etc. Unlimited maximum per Calendar year [Behavioral Telehealth - Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%]	[plan deductible] [then] [30-80]%]
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient services, [group psychotherapy] [Behavioral Telehealth] etc.) Unlimited maximum per Calendar year] [Behavioral Telehealth - Outpatient - All Other Services]]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Unlimited maximum per Calendar year	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Outpatient **Outpatient – Office Visits** Includes individual, family [and group] psychotherapy, medication management, [Behavioral Telehealth] etc. Unlimited maximum per Calendar year [Behavioral Telehealth - Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]% [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services [group psychotherapy], [Behavioral Telehealth] etc. [Behavioral Telehealth - Outpatient - All Other Services]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

Option for plans exempt from MHPA [**Mental Health**		
Inpatient	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient Includes Individual, Group and Intensive Outpatient [and Behavioral Telehealth]) Physician's Office Visit] [Behavioral Telehealth-Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]% [plan deductible] [then] [30-80]%]
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient Includes Individual, Group and Intensive Outpatient [and Behavioral Telehealth] Applies to Physician's Office and Outpatient Facility] [Behavioral Telehealth- Outpatient -– All Other Services] [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility deductible.]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then][30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [plan [then][30-80]%]] [plan deductible] [then] [30-80]%

Option for plans not subject to MHPA [**Substance Use Disorder**]		
Inpatient	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient (Includes Individual and Intensive Outpatient[and Behavioral Telehealth]**)** Physician's Office Visit] [Behavioral Telehealth–Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]% [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient Includes Individual and Intensive Outpatient Applies to Physician's Office and Outpatient Facility[and Behavioral Telehealth]] [Behavioral Telehealth-Outpatient - All Other Services] [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility deductible.]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

Option for plans not subject to MHPA [**Mental Health**		
Inpatient [Contract] [Calendar] Year Maximum: [60-Unlimited] days Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 [Residential: based on a ratio of 2:1] [Residential for Substance Use Disorder: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30--80]%
Outpatient	[Visits [1-40]:] [75-100%] after plan deductible [Visits [41-Unlimited]:] [60-100]%][after plan deductible]	[Visits [1-40]:] [75-100%] after plan deductible [Visits [41-Unlimited]:] [60-100]%][after plan deductible]

Outpatient Group Therapy [(One group therapy session equals one individual therapy session)] [[Contract] [Calendar] Year Maximum: [40-Unlimited] visits]	[$[0-150] per-visit copay] [then] [No charge]] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Based on a ratio of 1:1	[[$[0-2,500] per program copay] [then] [50-100]%]	[plan deductible] [then] [50-100]%

Option of Plan not subject to MHPA [**Substance Use Disorder**]		
Inpatient [Contract] [Calendar] Year Maximum: [60-Unlimited] days Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 [Residential: based on a ratio of 2:1] [Residential for Substance Use Disorder: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

Outpatient [Contract] [Calendar] Year Detoxification Maximum: [12-Unlimited] visits	[[Visits [1-40]:] [75-100%]] [[Visits [41-Unlimited]:] [[60-100%] per visit copay	[[Visits [1-40]:] [75-100%]] [[Visits [41-Unlimited]:] [60-100%] per visit copay]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Maximum: Each visit provided as part of a program accumulates to the Outpatient Substance Use Disorder benefit maximum on a 1:1 ratio basis with Outpatient Substance Use Disorder visits.	[[$[0-2,500] per program copay] [then] [50-100]%]	[plan deductible] [then] [50-100]%

Add variable text for Medical Pharmaceuticals with Medical.

Add variable text for Prescription Drug Products with Pharmacy based on plan design.

Important Information

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain [Medical Pharmaceuticals covered under your plan] [and] [Prescription Drug Products included on the Prescription Drug List]. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan's [Medical Pharmaceutical] [and] [Prescription Drug Product] benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

If Dependents are covered; add variable text.

Add "Medical Pharmaceuticals" with Medical.

Add "and" and "Prescription Drug Products" with Pharmacy based on plan design.

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you [or your Dependents] or to your Physician that communicate a variety of messages, including information about [Medical Pharmaceuticals] [and] [Prescription Drug Products]. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you [or your Dependents], at your discretion, to purchase the described [Medical Pharmaceutical] [and] [Prescription Drug Product] at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or

provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

Include variable text with Pharmacy.

[If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.
For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Co-insurance you are required to pay.]

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- [outpatient facility services;]
- Partial Hospitalization;
- [intensive outpatient programs;]
- [advanced radiological imaging;]
- non-emergency ambulance;
- [certain Medical Pharmaceuticals;] or
- transplant services.

Covered Expenses (Continued)

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

If Dependents are covered; add variable text.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you [or any of your Dependents] is a determination that is made by you [(or your Dependent)] and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

PRESCRIPTION DRUG BENEFITS

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, Limitations and Exclusions are provided below and are shown in The Schedule**.**

If Dependents are covered; add variable text.

For a 1 tier plan: Remove "which of the Prescription Drug List tiers the Prescription Drug Product is listed, or".

If you [or any one of your Dependents], while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Your benefits may vary depending on [which of the Prescription Drug List tiers the Prescription Drug Product is listed, or] the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you [or your Dependents] by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

If Dependents are covered; add variable text.

When you [or a Dependent] are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered by Cigna as if filled by a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy.

If Dependents are covered; add variable text.
For a 1 tier plan: Remove "coverage tiers" and "to a certain coverage tier" and "tier".

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List [coverage tiers] may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product [to a certain coverage tier] on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the

Prescription Drug Product and available rebates. When considering a Prescription Drug Product for [tier] placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you [or any of your Dependents] is a determination that is made by you [or your Dependent] and the prescribing Physician.

For a 1 tier plan, include "tier". For all other plans include "coverage".

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date [tier][coverage] status, utilization management, or other coverage limitations for a Prescription Drug Product.

PRESCRIPTION DRUG BENEFITS

Limitations

Include paragraph based on plan design.
If Dependents are covered; add variable text.

[In the event you [or your Dependent] insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required [Generic Drug] [Brand Drug] Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out of Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.]

Include paragraph based on plan design.
If Dependents are covered; add variable text.

[In the event you [or your Dependent]or your Physician insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by with the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required [Generic Drug] [Brand Drug] Copayment and/or Coinsurance. The amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out of Pocket Maximum.]

Remove variable text when Prior Authorization is not elected.

[Prior Authorization Requirements
Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior

authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.]

Include paragraphs based on plan design.

[Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.]

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Text may be included or removed.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. [If you are beginning a therapy regimen on a Specialty Prescription Drug Product, we may limit your coverage for the initial Prescription Order or Refill to multiple, separate fills of less than the total days' supply set forth in the Schedule of Benefits. If applicable, you will pay a pro-rated coinsurance or copayment amount for each such supply.]

Text may be included or removed.

[Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug Product. Refer to your Schedule of Benefits for further information.]

For 1 tier plans: Include "the". For all other plans include "a".

For 1 tier plans: Remove "tier", "tier placement" and "at the applicable coverage tier".

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on [the][a] Prescription Drug List [tier] upon its market entry. The Business Decision Team will use reasonable efforts to make a [tier placement] decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team's [tier placement] decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered [at the applicable coverage tier] as set forth in The Schedule.

PRESCRIPTION DRUG BENEFITS

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product will always be the lowest of:

Include all 3 bullets or vary to remove the second bullet based on client election.

- the Copayment or Coinsurance for the Prescription Drug Product; or
- [the Prescription Drug Charge for the Prescription Drug Product; or]
- the Pharmacy's Usual and Customary (U&C) Charge for the Prescription Drug Product.

If Dependents are covered; add variable text

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your [or your Dependent's] convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

Remove variable text for a 1 tier plan.

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered [at the applicable coverage tier] as set forth in The Schedule.

If Dependents are covered; add variable text.
Remove the last sentence based on plan design.

The amount you [or your Dependent] pay[s] for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. [You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.]

PRESCRIPTION DRUG BENEFITS

Remove variable text based on plan design, then change "the" to "The".

Exclusions

[Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition,] [t][T]he exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).

Delete w/diet drug coverage.

- [any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.]
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.

Delete w/prescription vitamin coverage.

- [vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.]
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.

Add for PPACA grandfathered or exempt plans that have not elected coverage.

- [Prescription Drug Products used for contraception.]

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Remove with oral infertility drug coverage.

- [Prescription Drug Products used for the treatment of infertility.]

Remove based on plan design.

- [Medical Pharmaceuticals covered solely under the plan's medical benefits.]

Delete w/lifestyle drugs (drugs to treat erectile dysfunction) coverage.

- [Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido.]
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA) [, and do not meet the definition of a Part D eligible drug].
- [Brand Drugs designated as non-preferred on the Prescription Drug List.]
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.

Include variable text based on plan design.

- [certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.]
- [any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.]

Include variable text based on plan design.

- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis [unless specifically identified on the Prescription Drug List].

Delete bullet w/smoking cessation product coverage.

Include bullet with PPACA Grandfathered or exempt, and include *"except those described in federal law as Preventive Care Medications"*.

Include first variable text piece for grandfathered and exempt if applicable. Include second variable text piece for non-grandfathered plans.

- [smoking cessation medications [except those described in federal law as Preventive Care Medications][except those required by federal law to be covered as Preventive Care Medications].

May be removed based on plan design.

- [certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.]

May be removed based on plan design.

- [medications that are experimental investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.]

May be removed based on plan design.

- [Prescription Drug Products used for the symptomatic treatment of cough and cold.]

May be removed based on plan design.

- [Prescriptions medications that do not meet the definition of a Part D eligible drug.]

Include any or all of the following exclusions for plans with Pharmacy coverage but without medical coverage.

- [care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Co-insurance you are required to pay.

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

If Dependents are covered; add variable text.

- [medical treatment for a person age 65 or older, who is covered under this plan as a retiree, [or their Dependent], when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.]
- [medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.]
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.]

Include this provision for plans with Pharmacy coverage but without medical coverage.

Include any of the following limitations.

[General Limitations

If Dependents are covered; add variable text.

No payment will be made for expenses incurred for you [or any one of your Dependents]:

- [for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.

If Dependents are covered; add variable text. For Employee only plans change "is" to "are".

- to the extent that you [or any one of your Dependents] [is][are] in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

If Dependents are covered; add variable text.

- charges made by any covered provider who is a member of your family [or your Dependent's family].
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.]]

PRESCRIPTION DRUG BENEFITS

Reimbursement/Filing a Claim

Retail Pharmacy

If Dependents are covered; add variable text.

When you [or your Dependents] purchase your Prescription Drug Products through a retail Network Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form unless you purchase a Prescription Drug Product at a non-Network Pharmacy.

Include variable text with home delivery benefits.

[Home Delivery Pharmacy

To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.]

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- [care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. [For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered [Service][Expense] (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered [Service][Expense], or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna.][[This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.] [Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Co-insurance you are required to pay.]
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies,

treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem
- The following services are excluded from coverage regardless of clinical indications: [Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Orthognathic Surgeries; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.]
- [[surgical] or [nonsurgical] treatment of TMJ disorders.]
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted [wisdom] tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth)..
- [for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.]
- [medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the

management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.]

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- [infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of sperm, eggs or embryos are also excluded from coverage.]
- [reversal of male or female voluntary sterilization procedures.]
- any [medications, drugs,] services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction
- [medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.]
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- [hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.]
- [aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers,

desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.]

- [aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.]
- corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of corrective lenses and associated services following treatment of keratoconus or cataract surgery.
- [Routine refractions,] eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- [treatment by acupuncture.]
- all noninjectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- [routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.]
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae [except for infant formula needed for the treatment of inborn errors of metabolism].
- [medical treatment for a person age 65 or older, who is covered under this plan as a retiree, [or their Dependent,] when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.]
- [medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.]
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- [telephone, e-mail, and internet consultations.]

- [telephone, e-mail, and internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.]
- [charges for Care Management and Care Coordination Services except when provided by designated health care professionals who participate in specific collaborative arrangements.]
- [charges for the delivery of [behavioral] [and] [medical] [and] [health][-related] services via telecommunications technologies, including telephone and internet [unless in a geo-remote area] [and] [or] [unless provided as specifically described under Covered Expenses.]]
- massage therapy.
- [abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.]
- [certain Medical Pharmaceuticals that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Medical Pharmaceutical(s) and is administered in connection with a covered service rendered in an [inpatient], [outpatient], [Physician's office] or [home health care] setting. Such determinations may be made periodically, and benefits for a Medical Pharmaceutical that was previously excluded under this provision may be reinstated at any time.]

General Limitations

No payment will be made for expenses incurred for you [or any one of your Dependents]:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you [or any one of your Dependents] is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- [to the extent that they are more than Maximum Reimbursable Charges.]
- [to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received out of network (for example, emergency care).]
- [for in-network only medical plans, to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received out of network (for example, emergency care). For other than in-network only medical plans, to the extent that they are more than Maximum Reimbursable Charges.]
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

- charges made by any covered provider who is a member of your family [or your Dependent's Family].
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.]

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

SUBROGATION/RIGHT OF REIMBURSEMENT

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

LIEN OF THE PLAN

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

ADDITIONAL TERMS

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

RIGHT OF REIMBURSEMENT

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

LIEN OF THE PLAN

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

ADDITIONAL TERMS

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine

purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in the pursuit of its right of recovery. The plan's recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any recovery rights by providing requested information.

COORDINATION OF BENEFITS

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical [or dental] [or vision]care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

The amount of charges considered for payment under the plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the

basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended.

However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

[The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

(1) Cigna's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.]

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

MEDICARE ELIGIBLES

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan.

PAYMENT OF BENEFITS

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.
You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a Non-participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you, you or your Dependents are responsible for reimbursing the Non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

[Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- [Its published reimbursement and payment policies.]
- [the methodologies in the most recent edition of the Current Procedural terminology.]
- [coding and payment methodologies of Centers for Medicare & Medicaid Services CMS.]

- [the methodologies as reported by generally recognized professionals or publications.]]

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or

- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

DEFINITIONS

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

DEFINITIONS

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

DEFINITIONS

Include “Prescription Drug Products” and “or” with pharmacy based on plan design.
Include "Medical Pharmaceuticals” with medical.

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of [Prescription Drug Products] [or] [Medical Pharmaceuticals] based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to [Prescription Drug Products] [or] [Medical Pharmaceuticals].

DEFINITIONS

Cigna Home Delivery Pharmacy

A home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company.

DEFINITIONS
include in plans with dependent coverage

Dependent

Dependents are:

- [your lawful spouse of the same or opposite sex who is legally married to you under the laws of the state or jurisdiction in which the marriage took place;]

  [who is not eligible for health coverage through his/her own Employer][or required to contribute more than 50% of the cost of such coverage][or]

- Your Civil Union Partner; or
- [your Domestic Partner;] and
- any child of yours who is
  - less than 26 years old.
- [your eligible dependent as determined under the terms of the Employer's plan and reported by the Employer to Cigna;] and
  - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student at least 5 calendar months in a calendar year (or eligible but prevented from enrollment solely because of Injury or Sickness) and primarily supported by you.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    [Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.]

The term child means a child born to you or a child legally adopted by you beginning from the first day of placement in your home. It also includes a stepchild. A child also includes a minor grandchild, niece or nephew for whom you provide food, clothing and shelter on a regular and continuous basis when the District of Columbia schools are in regular session, provided such child's legal guardian, if not you, is not covered by an accident or Sickness policy. If your Civil Union partner has a child, that child will also be included as a Dependent. [If your Domestic Partner has a child, that child will also be included as a Dependent.]

[Benefits for a Dependent child or student will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.]

[Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.]

[Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.]

DEFINITIONS
include in plans with dependent coverage

Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

A Civil Union is a same-sex relationship similar to marriage that is recognized by law.

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

DEFINITIONS

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

DEFINITIONS

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer’s plan.

DEFINITIONS

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna's Business Decision Team makes a Prescription Drug List coverage status decision.

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

DEFINITIONS

Include "Medical Pharmaceuticals" with medical. Include "or" and "Prescription Drug Products, including New Prescription Drug Products,*" with Pharmacy based on plan design.*

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews [Medical Pharmaceuticals] [or] [Prescription Drug Products, including New Prescription Drug Products,] for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Remove variable text based on plan design.

Prescription Drug Charge

The amount the plan pays to Cigna, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy. [Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the plan pays to Cigna.]

DEFINITIONS

Remove variable text with pharmacy coverage for 1 tier plans.

Prescription Drug List

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) [into coverage tiers]. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. [You may determine to which tier a particular Prescription Drug Product has been assigned [through the website shown on your ID card or by calling customer service at the telephone number on your ID card.]]

Remove variable text for retiree pharmacy plans where coverage for these items is provided under Medicare Part B.

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, [injection aids,] [insulin pump accessories (but excluding insulin pumps),] needles including pen needles, syringes[, test strips, lancets, urine glucose and ketone strips];
- [Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and]
- [Inhaler assistance devices and accessories, peak flow meters.]

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication [through the Internet website shown on your ID card or] by calling member services at the telephone number on your ID card.

DEFINITIONS

Include "Prescription Drug Product" and "or" based on plan design.

Include "Medical Pharmaceutical" with medical.

Remove "or tier assignment" if client has a pharmacy plan with 1 tier coverage.

Specialty Prescription Drug Product

A [Prescription Drug Product] or][Medical Pharmaceutical] considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the [Prescription Drug Product] [or] [Medical Pharmaceutical] is prescribed and used for the treatment of a complex, chronic or rare condition; whether the [Prescription Drug Product] [or] [Medical Pharmaceutical] has a high acquisition cost; and, whether the [Prescription Drug Product] [or] [Medical Pharmaceutical] is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a [Prescription Drug Product] [or] [Medical Pharmaceutical] will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, [or by tier assignment] or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

DEFINITIONS

Include variable text based on plan design.

Therapeutic Alternative

A [Prescription Drug Product][or] [Medical Pharmaceutical] that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another [Prescription Drug Product][, Medical Pharmaceutical] or over-the-counter medication.

DEFINITIONS

Include variable text with based on plan design.

Therapeutic Equivalent

A [Prescription Drug Product] [or] [Medical Pharmaceutical] that is a pharmaceutical equivalent to another [Prescription Drug Product][,] [Medical Pharmaceutical] or over-the-counter medication.

Usual and Customary (U&C) Charge

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

Non-PPACA Preventive Medication

Prescription Drug Products taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered. However, this does not include any drugs or medications used to treat an existing illness, Injury or condition. The term Non-PPACA Preventive Medication does not include medications covered at 100% as required as preventive care services by PPACA, the terms of coverage for which are addressed separately in this plan.

DEFINITIONS

Include this definition with pharmacy plans that waive the deductible, coinsurance or copay for Non-PPACA Preventive Drugs.

Preventive Medication

Prescription Drug Products taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered. However, this does not include any drugs or medications used to treat an existing illness, Injury or condition.

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by the Medical Director to be:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family [or your Dependent's family], for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration
- [charges made for diagnosis and treatment of: corns, calluses, weak or flat feet; any fallen arches, chronic foot strain or instability or imbalance of the feet; toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).]
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- [charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted

medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).]

- [charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services and vasectomies.]
- [abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, tubal ligations, vasectomies, [elective abortions] and infertility testing.
- [charges made for the following preventive care services (detailed information is available at www.healthcare.gov):

  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.]
- [charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.]
- [charges made for acupuncture/acupressure.]
- [charges made for hearing aids and associate exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversation.]
- [charges made for orthognathic surgery.]
- [On-line physician visits through an approved internet-based intermediary (dependent upon product and availability).]
- [Includes charges for the delivery of [medical] [and] [health][-related] [consultations] [and] [coaching] [and] [remote monitoring] [and] [services] via secure telecommunications technologies, [including [telephones] [and] [internet]],

when delivered through a [designated] [contracted] [medical] [provider] [or] [facility] [and] [or] telehealth provider [or] [telehealth facility].]

- [charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.]
- [charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically necessary.][and]
- [charges made for gender reassignment surgery (male-to-female or female-to-male) [and related services consistent with World Professional Association for Transgender Health (WPATH) recommendations] including, when applicable, hormone therapy, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy and salpingo-oophorectomy, as well as initial mastectomy or breast reduction.]
- charges made for uniform, age-appropriate health screenings consistent with the standards and schedules of the American Academy of Pediatrics for a Dependent Child to age 21.
- for a child under 21 who has a congenital or genetic birth defect, charges made for physical, occupational or speech therapy which enhances the child's ability to function. Coverage will not be provided for Habilitative Services delivered through early intervention or school services programs. [The age limit does not apply to treatment for autism.]
- charges made for or in connection with a baseline mammogram, an annual screening mammogram, or PAP tests on an annual basis or more frequently if certified as Medically Necessary by the attending Physician.
- charges made for diabetic services for insulin-using diabetes, noninsulin-using diabetes and gestational diabetes. Services and supplies including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits.
- charges for the equipment, supplies and other outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a qualified health care-professional authorized to prescribe such items.

[Include w/o carve-out Pharmacy.]

- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips and urine test strips; and injection aids (i.e. lancets, alcohol swabs).
- charges for colorectal cancer screening, specifically, screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate

circumstances radiologic imaging, in accordance with the most recent published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

- charges made for a voluntary Human Immunodeficiency Virus (HIV) screening test performed on a member while the member is receiving emergency medical services at a hospital, subject to a limitation of one annual test per member.
- charges made for oral chemotherapy medications.
- charges made for hormone replacement therapy drugs that are prescribed for treating symptoms and conditions of menopause.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per [contract] [calendar] year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

[Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of phenylketonuria (PKU). Coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.

- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.]

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

SERFF Tracking #:	*CCGH-130795901*	***State Tracking #:***		***Company Tracking #:***	*HC-SOC567*

State:	*District of Columbia*	***Filing Company:***	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002C Large Group Only - Other*		
Product Name:	*2016 Regulatory Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Description of Variable
Comments:	
Attachment(s):	Description of Variable 2016 RF.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Listing of forms
Comments:	
Attachment(s):	Listing of Medical.Rx Forms DC.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined changes made to previously approved forms
Comments:	
Attachment(s):	HC-COV534 Covered Expenses clean rd.pdf HC-DFS876 Medically Necessary rd.pdf HC-DFS877 Definition of Dependent rd.pdf HC-SOC568 Med Sch rd.pdf HC-EXC234 Exclusions RED.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover letter
Comments:	
Attachment(s):	Cover Letter 2016 RF DC.pdf
Item Status:	
Status Date:	

Cigna Health and Life Insurance Company

Statement of Variability
Forms HC-SOC567 et al

General

1. To the extent that variable changes are made, they will not be ambiguous or deceptive.

2. Titles or names – such as the product name – may change, but their relation to the matter to which they pertain will not be ambiguous or deceptive.

3. Fill in text has been presented in "John Doe" format.

4. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.

5. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to: benefit provisions may be rewritten at the request of a Policyholder to clarify the Policyholder's understanding of benefits and/or administration.

6. Schedule items may be varied to reflect Policyholder election (e.g. a "copay" cost sharing option is elected for a coverage item rather than a "coinsurance" cost-sharing option). Possible numerical values available to Policyholder's are expressed by a defined range in the Schedule (i.e., a copayment dollar amount range, a coinsurance percentage range, a day or visit maximum range or contract, calendar year or lifetime dollar maximum range). Policyholders may elect any numerical value within the identified range.

7. Proposed Exclusion text has been marked variable to allow a Policyholder to include all, or some, of the proposed exclusions.

8. Proposed Covered Expenses text has been marked variable to allow a Policyholder to include all, or some, of the proposed coverage items.

9. Definitions may be included or deleted, based on Policyholder plan design election.

Specific Forms

- Provisions will be included or deleted, based on Policyholder plan design election.

Form HC-IMP188: Important Information- Rebates and Coupons

• Text will vary in accordance with italicized descriptions on the pages.
- Variable text may be included or excluded to reflect policyholder election or plan design.

Form HC-PRA26: Prior Authorization/Pre-Authorized

•Service subject to prior authorization may vary based on program enhancements.
•Include reference to outpatient facility services and advanced radiological imaging based on Policyholder certification program election.
•Remove reference to intensive outpatient programs based on Policyholder plan feature election.
•Remove reference to certain Medical Pharmaceuticals based on Policyholder certification program election.

Form HC-COV526: Covered Expenses- Medical Pharmaceuticals

- Add bracketed text pieces per Policyholder plan specification.

Forms HC-PHR136: RX Covered Expenses, HC-PHR137: RX Limitations, HC-PHR138: RX Your Payments, HC-PHR139: RX Exclusions, HC-PHR140: RX Reimbursement, HC-SOC567: RX Schedule

- Text will vary in accordance with italicized descriptions on the pages.
- Variable text may be included or excluded to reflect policyholder election or plan design.

Form HC-EXC234: Exclusions, Expenses Not Covered and General Limitations

- Include bulleted items based on Policyholder plan specifications.

Form HC-COB135: Coordination of Benefits

- References to Medicare Eligibles will be removed if Policyholder elects not to coordinate benefits with Medicare.
- Benefit Credit Reserve will be included based on Policyholder plan specifications.

Form HC-POB89 Payment of Benefits

- The page, in its entirety, may be removed for a Prescription Drug or Vision Standalone plan.
- Plan coverage references may vary based on Policyholder election.
- Bracketed text will be included or deleted, based on Policyholder election.

Form HC-DFS840 et al.: Definitions

- Include definitions necessary to describe coverage based on Policyholder election.
- Add bracketed text pieces per Policyholder plan specification.

DC Listing of Forms

HC-SOC567	The Schedule Pharmacy
HC-SOC568	The Schedule Medical
HC-IMP188	Important Information – Rebates and Other Payments
HC-PRA26	Prior Authorization/Pre-Authorized
HC-COV526	Covered Expenses-Medical Pharmaceuticals
HC-COV534	Covered Expenses
HC-PHR136	Prescription Drug Benefits - Covered Expenses
HC-PHR137	Prescription Drug Benefits - Limitations
HC-PHR138	Prescription Drug Benefits - Your Payments
HC-PHR139	Prescription Drug Benefits - Exclusions
HC-PHR140	Prescription Drug Benefits - Reimbursement
HC-EXC234	Exclusions
HC-SUB77	Expenses for Which a Third Party May Be Responsible/Subrogation
HC-SUB78	Expenses for Which a Third Party May Be Responsible/Right of Recovery
HC-COB135	Coordination of Benefits
HC-COV533	Covered Expenses
HC-POB89	Payment of Benefits
HC-AAR1	Appointment of Authorized Representative
HC-DFS840	Biologic
HC-DFS841	Biosimilar
HC-DFS842	Brand Drug
HC-DFS843	Business Decision Team
HC-DFS844	Cigna HD Pharmacy
HC-DFS877	Definition of Dependent
HC-DFS845	Designated Pharmacy
HC-DFS846	Generic Drug
HC-DFS847	Maintenance Drug Product
HC-DFS848	Medical Pharmaceutical
HC-DFS876	Medically Necessary
HC-DFS849	Network Pharmacy
HC-DFS850	New Prescription Drug Product
HC-DFS851	Pharmacy
HC-DFS852	P & T Committee
HC-DFS853	Prescription Drug Charge
HC-DFS854	Prescription Drug List
HC-DFS855	Prescription Drug Product
HC-DFS856	Prescription Order or Refill
HC-DFS857	Preventive Care Medications
HC-DFS858	Specialty Prescription Drug Product
HC-DFS859	Therapeutic Alternative
HC-DFS860	Therapeutic Equivalent
HC-DFS861	Usual & Customary Charge
HC-DFS864	Non-PPACA Preventive Medication
HC-DFS873	Preventive Medication

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family [or your Dependent's family], for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration
- [charges made for diagnosis and treatment of: corns, calluses, weak or flat feet; any fallen arches, chronic foot strain or instability or imbalance of the feet; toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).]
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- [charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted

medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).]

- [charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services and vasectomies.]
- [abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, tubal ligations, vasectomies, [elective abortions] and infertility testing.
- [charges made for the following preventive care services (detailed information is available at www.healthcare.gov):

  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.]
- [charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.]
- [charges made for acupuncture/acupressure.]
- [charges made for hearing aids and associate exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversation.]
- [charges made for orthognathic surgery.]
- [On-line physician visits through an approved internet-based intermediary (dependent upon product and availability).]
- [Includes charges for the delivery of [medical] [and] [health][-related] [consultations] [and] [coaching] [and] [remote monitoring] [and] [services] via secure telecommunications technologies, [including [telephones] [and] [internet]],

when delivered through a [designated] [contracted] [medical] [provider] [or] [facility] [and] [or] telehealth provider [or] [telehealth facility].]

- [charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.]
- [charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically necessary.][and]
- [charges made for gender reassignment surgery (male-to-female or female-to-male) [and related services consistent with World Professional Association for Transgender Health (WPATH) recommendations] including, when applicable, hormone therapy, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy and salpingo-oophorectomy, as well as initial mastectomy or breast reduction.]
- charges made for uniform, age-appropriate health screenings consistent with the standards and schedules of the American Academy of Pediatrics for a Dependent Child to age 21.
- for a child under 21 who has a congenital or genetic birth defect, charges made for physical, occupational or speech therapy which enhances the child's ability to function. Coverage will not be provided for Habilitative Services delivered through early intervention or school services programs. [The age limit does not apply to treatment for autism.]

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- charges made for or in connection with a baseline mammogram, an annual screening mammogram, or PAP tests on an annual basis or more frequently if certified as Medically Necessary by the attending Physician.
- charges made for diabetic services for insulin-using diabetes, noninsulin-using diabetes and gestational diabetes. Services and supplies including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits.
- charges for the equipment, supplies and other outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a qualified health care-professional authorized to prescribe such items.

[Include w/o carve-out Pharmacy.]

- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips and urine test strips; and injection aids (i.e. lancets, alcohol swabs).
- charges for colorectal cancer screening, specifically, screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate

circumstances radiologic imaging, in accordance with the most recent published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

- charges made for a voluntary Human Immunodeficiency Virus (HIV) screening test performed on a member while the member is receiving emergency medical services at a hospital, subject to a limitation of one annual test per member.
- charges made for oral chemotherapy medications.
- charges made for hormone replacement therapy drugs that are prescribed for treating symptoms and conditions of menopause.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per [contract] [calendar] year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

[Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of phenylketonuria (PKU). Coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.

- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.]

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

DEFINITIONS

Medically Necessary/Medical Necessity

Health care services, supplies and ~~Supplies~~ medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are ~~those~~all of the following as~~Medically Necessary Covered Services and Supplies are those~~ determined by the Medical Director to be:

- required to diagnose or treat an illness, I~~i~~njury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; ~~and~~
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, ~~and~~ supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings ~~or supplies~~ when determining least intensive setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

DEFINITIONS
include in plans with dependent coverage

Dependent

Dependents are:

- [your lawful spouse of the same or opposite sex who is legally married to you under the laws of the state or jurisdiction in which the marriage took place;]

  [who is not eligible for health coverage through his/her own Employer][or required to contribute more than 50% of the cost of such coverage][or]

- Your Civil Union Partner; or
- [your Domestic Partner;] and
- any child of yours who is
  - less than 26 years old.
- [your eligible dependent as determined under the terms of the Employer's plan and reported by the Employer to Cigna;] and
  - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student at least 5 calendar months in a calendar year (or eligible but prevented from enrollment solely because of Injury or Sickness) and primarily supported by you.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

  [Proof of the child's condition and dependence ~~must~~ may be required to be submitted to the plan~~Cigna~~ within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan~~Cigna~~ may require proof of the continuation of such condition and dependence.]

The term child means a child born to you or a child legally adopted by you beginning from the first day of placement in your home. It also includes a stepchild. A child also includes a minor grandchild, niece or nephew for whom you provide food, clothing and shelter on a regular and continuous basis when the District of Columbia schools are in regular session, provided such child's legal guardian, if not you, is not covered by an accident or Sickness policy. If your Civil Union partner has a child, that child will also be included as a Dependent. [If your Domestic Partner has a child, that child will also be included as a Dependent.]

[Benefits for a Dependent child or student will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.]

[Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.]

[Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.]

DEFINITIONS
include in plans with dependent coverage

Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

A Civil Union is a same-sex relationship similar to marriage that is recognized by law.

[Plan Name] Medical Benefits **The Schedule**
For You [**and Your Dependents**]
[Network] [Network Open Access] [Exclusive Provider Organization][Open Access Plus In-Network] [Comprehensive] [Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive [Point of Service] [Point of Service Open Access] [Preferred Provider Organization] [Open Access Plus] Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.
[If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.]
Coinsurance The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan. [**Copayments/Deductibles** Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. [Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.]]
[Out of Pocket Expenses – [For In-Network Charges Only] Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.]
[Out of Pocket Expenses –[For Out-of-Network Charges Only] The Schedule **Out-of-Pocket Expenses** Out-of-Pocket Expenses are Covered Expenses incurred for [In-Network][and][Out-of-Network] charges that are not paid by the benefit plan. The following [In-Network] [and] [Out-of-Network] Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%. [Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, In-Network copayments and Out-of-Network deductibles are no longer required.] • [Coinsurance] • [Plan Deductible] • [coinsurance][and][copayments][and][Per Day][deductibles]] [for the following:]   • [inpatient hospital facility]

- [outpatient facility]
- [Advanced Radiological Imaging]
- [emergency room]
- [office visit]
- [urgent care]
- [Obesity/Bariatric [surgery] [treatment]]
- [infertility]
- [hearing aids]
- [External Prosthetic Appliances]
- [[Medical] [and] [Pharmacy] [Cigna Pharmacy][Mail Order Pharmacy]
- [Mental Health] [and] [Substance Use Disorder] [Ambulance]
- [Ambulatory Free Standing Surgical]
- [DME life sustaining]
- [Medical Supplies]
- [Acupuncture]
- [TMJ]
- [Home Health Care]
- [Hospice]
- [Outpatient Short-Term Rehabilitation]
- [Chiropractic Services]
- [Skilled Nursing]

The following Out-of-Pocket [In-Network] [and] [Out-of-Network] Expenses and charges do not contribute to the Out-of-Pocket Maximum and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached.

- [non-compliance penalties]

  If exempt from MHPA
- [Out-of-Network Outpatient [Mental Health] [and Substance Use Disorder treatment]]
- [provider charges in excess of the Maximum Reimbursable Charge]
- [Coinsurance]
- [Plan Deductible]
- [coinsurance][and][copayments][and][deductibles] [for the following:]
  - [inpatient hospital facility]
  - [outpatient facility]
  - [Advanced Radiological Imaging]

- [emergency room]
- [office visit]
- [urgent care]
- [Obesity/Bariatric [surgery] [treatment]]
- [infertility]
- [hearing aids]
- [External Prosthetic Appliances]
- [[Medical] [and] [Pharmacy] [Cigna Pharmacy][Mail Order Pharmacy]
- [Mental Health] [and] [Substance Use Disorder]
- [Lab and X-ray]
- [Ambulance]
- [Ambulatory Free Standing Surgical]
- [DME life sustaining]
- [Medical Supplies]
- [Acupuncture]
- [TMJ]
- [Home Health Care]
- [Hospice]
- [Outpatient Short-Term Rehabilitation]
- [Chiropractic Services]
- [Skilled Nursing]]

[**Note:**
For information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan, refer to **What You Should Know about Cigna Choice Fund**.]

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

[Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, [Out-of-Network will accumulate to In-Network] [In-Network will accumulate to Out-of-Network]). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]

[Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). However, all other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. [All In-Network services must be performed by the Primary Care Physician (PCP) or referred by the PCP.]]

[Accumulation of Pharmacy Benefits

If your plan provides Pharmacy benefits separately, any [In-Network] medical Out-of-Pocket Maximums will cross accumulate with any [In-Network] Pharmacy Out-of-Pocket Maximums.]

[**Contract Year**

Contract Year means a twelve month period beginning on each [Month] [Date].]

[**Guest Privileges**

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.]

[**Assistant Surgeon and Co-Surgeon Charges**

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.]

[Out-of-Network Emergency Services Charges]

1 [Emergency services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.]

2 [The allowable amount used in determining benefit payments for emergency services provided in the emergency department of a non-participating (Out-of-Network) Hospital is the greatest of the following: (i) the median amount negotiated with In-Network providers for the emergency service (excluding In-Network copay or coinsurance); (ii) the Maximum Reimbursable Charge, or (iii) the amount payable under the Medicare program (not to exceed the provider's billed charges).]

3 [The allowable amount used in determining benefit payments when Out-of-Network Emergency services result in an inpatient admission is the median amount negotiated with In-Network facilities.]

[The member is responsible for the applicable In-Network cost-sharing amounts, plus all charges in excess of the allowable amount set forth in #2 and [#3] above.]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Lifetime Maximum for essential benefits	Unlimited] [10,000-Unlimited]**	
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]	[$10,000-Unlimited]]
[**Lifetime Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for non-essential benefits**	[$10,000-Unlimited]]	
[**Annual Maximum for non-essential benefits**	[Not Applicable] [$10,000-Unlimited]	[$10,000-Unlimited]
** For use with plans exempt from PPACA only.		
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	[50-100]%	[30-80]% [of the Maximum Reimbursable Charge] [see below]
[**Maximum Reimbursable Charge** [(Maximum Reimbursable Charge limits do not apply to charges for covered Out-of-Network Emergency Services provided in an emergency department of a Hospital)] Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
• [A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.]	Not Applicable	[70-90]th Percentile]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[**Medical Charges**] [A percentage of a fee schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the [70-90]th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.] • [[0 – 60%] of the provider's normal charge (i.e., the charge made to patients without coverage) for a similar service or supply]	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[Out of Network: • [Facility Services • Professional Services/Other Services (Non-Professional & Non-Facility)] [Charges for services such as Laboratory, Radiology, Pathology and Anesthesia, that are provided by an Out-of-Network provider, in an In-Network facility, while you are receiving In-Network services at that In-Network facility are covered In-Network.] • [Facility Services • Professional Services/Other Services (Non-Professional & Non-Facility)]] (excludes Mental Health and Substance Use Disorder)		[[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge] [[100-500]%- [30% - 80%] of Maximum Reimbursable Charge]
[**Mental Health And Substance Use Disorder** • A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database Cigna has selected. [If sufficient charge data is unavailable in the database for that geographic area, then state, regional or national charge data will be used. If sufficient national charge data is unavailable in the database, then data in the database that is derived from charges for other services will be used.]	Not Applicable	[70-90]th Percentile]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Note: In addition to applicable deductible, co-payments and coinsurance payments, you are responsible for any charges above the Maximum Reimbursable Charge.]		
[**Automatic Reinstatement** The total amount of Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule. However, once a person uses any portion of his Maximum Benefit, on each January 1, Cigna will reinstate the used amount up to $[1,000-5,000] to be applied to Covered Expenses incurred after the date of reinstatement.]		
[[**Contract**] [**Calendar**] **Year Deductible** Individual [Applies when Employee only is covered under the plan]	[$[0-10,000] per person] [Not Applicable]	[$[0-10,000] per person] [Not Applicable]
Family Maximum	[$[0-30,000] per family] [Not Applicable]	[$[0-30,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Family Maximum Calculation **Individual Calculation** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.]		
[**Combined Medical/Pharmacy** [**Contract**] [**Calendar**] **Year**		
Combined Medical/Pharmacy Deductible: includes retail and home delivery~~mail order~~ drugs Home Delivery~~Mail Order~~ Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	[No] [Yes] [No] [Yes]	[No] [Yes] [In-Network Coverage only] [No] [Yes]]
[RX cap contribution to the combined Medical/Pharmacy Deductible **Note:** Once the RX cap amount or the combined Medical/Pharmacy deductible has been met, the terms of the Pharmacy plan benefits are applicable.	$[0-900]	[In-Network Coverage only] $[0-900]]
[**Out-of-Pocket Maximum**		
Individual Individual [–Employee Only] [Individual – within a Family] [Applies when Employee only is covered under the plan]	Note: for 2016 NGF plans:[$[0-6,850] per person], [I~~i~~ndexed A~~a~~nnually] Note: for GF or Exempt plans: [$[0-30,000] per person] [Not Applicable]	[$[0-90,000] per person] [Not Applicable]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Family Maximum	Note: for 2016 NGF with Collective Out-of-Pocket Maximum [$[0-6,850] [Iindexed Aannually] Note: for NGF plans with Individual Calculation Out-of-Pocket Maximum: [$[0-13,700] Note: for GF or Exempt plans $[0-90,000] per family [Not Applicable]	[$[0-90,000] per family] [Not Applicable]]
[Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family deductible has been satisfied.]	Note: may be used for NGF only if Out of Pocket Maximum is less than or equal to mandated self only Individual Out of Pocket Maximum.	
[Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.]		
[**Combined Medical/Pharmacy Out-of-Pocket Maximum**		
Combined Medical/Cigna Pharmacy Out-of-Pocket: includes retail and home delivery~~mail order~~ drugs Home Delivery ~~Mail Order~~ Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	[No] [Yes] [No] [Yes]	[No] [Yes] [In-Network coverage only] [No] [Yes]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[RX cap contribution to the combined Medical/Pharmacy Out-of-Pocket maximum Once the RX cap amount has been met or the total Out of Pocket maximum has been met, the terms of the Pharmacy plan benefits are applicable and subject to: Option 1: Pharmacy paid at 100% once the cap amount has been met. Option 2: Pharmacy continued to be paid at the Pharmacy Program levels (i.e. copay, coinsurance)[until Out of Pocket Maximum is met, then at 100%]	$[0-30,000]	[In-Network coverage only] $[0-30,000]]
Physician's Services		
Primary Care Physician's Office visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2-Unlimited] [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%
Surgery Performed In the Physician's Office	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Second Opinion Consultations (provided on a voluntary basis)	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Allergy Treatment/Injections	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Allergy Serum (dispensed by the Physician in the office)	[No charge] [Primary Care Physician] [plan deductible] [then] [50-100]% [Specialty Care Physician] [plan deductible] [then] [50-100]%	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Convenience Care Clinics [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Medical Telehealth ~~[Visit(s) 1-10]~~ ~~[Visits 2-Unlimited]~~ ~~[Visits 2-Unlimited]~~	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network Coverage Only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
THE SCHEDULE		
Preventive Care		[Unlimited] [$250-$2,000]*
	In-Network Benefits	Out of Network Benefits
[**Preventive Care** [Routine Preventive Care : Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)] [Routine Preventive Care (for children through age 20)] [Routine Preventive Care (for ages 21 and over)] [**Note:** Well-Woman OB/GYN visits will be considered a Specialist visit.] [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Preventive X-ray and/or Lab Services	[No Charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Immunizations [for children through age 20)] [for ages 21 and over)]	[No charge]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
[[**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]		
Physician's Office Visit	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [[plan deductible] [then] [30-80]%] [Specialty Care Physician] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Immunizations	[No charge] [Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Mammograms, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible]	No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible
PSA Preventive Care Related Services (i.e. "routine" services)	[plan deductible] [then] [No Charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [No charge] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Preventive Care Related Services (i.e. "routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service
Mammograms and PAP Smear [Diagnostic Related Services (i.e. "non-routine" services)	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible] [No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%	[No charge for the first mammogram and/or pap test per Contract/Calendar year. Additional mammograms and/or pap tests are subject to !% after plan deductible] [No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%
PSA [Diagnostic Related Services (i.e. "non-routine" services)	[No Charge] [plan deductible] [then] [No charge] [[plan deductible] [then] [50-100]% [if billed by an independent diagnostic facility or outpatient hospital]] [plan deductible] [then] [50-100]%	[plan deductible] [then] [No charge] [plan deductible] [then] [30-80]%
[Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
	[**Note:** The associated wellness exam will be covered at no charge after the $[0-100] PCP or $[0-150] Specialist per visit copay] [**Note:** The associated wellness exam is subject to the $[0-100] PCP or $[0-150] Specialist per office visit copay]	[**Note:** The associated wellness exam is not covered]
*Variables Applicable to plans Exempt from PPACA only. Cost Share applied to In Network Benefits Applicable to Exempt and Grandfathered Plans only.		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital - Facility Services	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Semi-Private Room and Board	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Ambulatory Free Standing Surgical Centers **[for][arthroscopy]** **[colonoscopy]** **[endoscopy]**		
Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The [facility copay] [facility deductible] [facility copay or facility deductible] will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the [facility copay] [facility deductible] [facility copay or facility deductible].]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Inpatient Hospital Physician's Visits/Consultations	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Surgeon Radiologist Pathologist Anesthesiologist	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Outpatient Professional Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Surgeon Radiologist Pathologist Anesthesiologist	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Emergency Care] [and] [Urgent Care Services]		
[If you receive Out-of-Network Emergency Services [provided in an emergency department of a Hospital] and the provider bills you for an amount higher than the amount you owe indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.]		
Urgent Care Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Urgent Care Facility or Outpatient Facility Outpatient Professional Services (radiology, pathology, and physician) X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) The scan copay/deductible applies per type of scan per day	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%] All Scan Maximums shown under Advanced Radiological Imaging MRI Per Scan Maximum apply	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]
Emergency Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Hospital Emergency Room Outpatient Professional Services (radiology, pathology, and ER physician) X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit) Independent x-ray and/or Lab Facility in conjunction with an ER visit	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%	[No charge] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [No charge] [(*Copay waived if admitted)]] [[$[0-750] per visit copay*] [then] [plan deductible] [then] [50-100]% [(*Copay waived if admitted)]] [[plan deductible] [then] [$[0-750] per visit copay*] [then] [50-100]% [(*Copay waived if admitted)]] [plan deductible] [then] [50-100]%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) The scan copay/deductible applies per type of scan per day	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%] All Scan Maximums shown under Advanced Radiological Imaging MRI Per Scan Maximum apply	[[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]
Ambulance		
[Maximum not to exceed $750-75,000] [**][per][year][day][visit][trip]	[No charge[**]] [$[50-5,000] [per day][per trip] copay then[50-100]%] [[plan deductible] [then] [50-100]%] [** If not a true emergency, services are not covered]	[No charge[**]] [$[50-5,000] [per day][per trip] [copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities [Contract] [Calendar] Year Maximum: [[3-Unlimited] days combined] [[3-Unlimited] days for Skilled Nursing Facility; [30-Unlimited] days for Rehabilitation Hospital; [30-Unlimited] days for Sub-Acute Facilities] [No prior hospitalization required]	[$[0-4,500] per day copay] [then] [No charge]] [[$[0-4,500] per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per day copay] [then] [50-100]%] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per day deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per day deductible] [then] [30-80]%] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Other Laboratory[[and] [Radiology Services:]		
Laboratory Services in a Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Laboratory Services in an Outpatient Facility [Tier 1] [Tier 2 -] [Tier 3- Out of Network]	[[plan deductible] [then] [50-100]% for facility charges; [[plan deductible] [then] [50-100]% for outpatient professional charges] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
Laboratory Services at an Independent Lab facility [Tier 1][National Lab] [Tier 2][Other Cigna Participating Lab] [Tier 3][Out of Network]	[No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Radiology Services in a Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Radiology Services at an Outpatient Facility [Tier 1] [Tier 2 -] [Tier 3- Out of Network]	[[plan deductible] [then] [50-100]% for facility charges; [[plan deductible] [then] [50-100]% for outpatient professional charges] [[plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Advanced Radiological Imaging **(i.e. MRIs, MRAs, CAT Scans and PET Scans** [**and Nuclear Medicine**]**)** [The scan copay/deductible applies per type of scan per day] [MRI and CAT Per Scan Maximums Apply Regardless of Place of Service]		
[MRI][MRA][CAT][PET] Per Scan Maximum] [Head] [Leg] [Arm] [Abdomen] [Abdomen/Chest] [Head/Neck/Face] [Body Part] [Each Other Body Part]	 $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000]	 $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000] $[50-30,000]]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visit [MRI][CAT][PET][All other Scans]	[$[0-1,000] per scan copay] [then] [No charge]] [[$[0-500] per scan copay] [then] [plan deductible] [then] [50-100]%] [plan deductible] [then] [50-100]% [Primary Care Physician] [[$[0-500] per scan copay] [then] [$[0-100] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [$[0-100] per office visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-500] per scan copay] [then] [$[0-150] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [$[0-150] per office visit copay] [then] [50-100]%]	[$[0-1,000] per scan deductible] then [plan deductible] [then] [30-80]%] [[plan deductible] [then][$[0-1,000] per scan deductible] [then] [30-80]%] [plan deductible] [then] [30-80]% [Primary Care Physician] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-1,000] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-1,000] per scan copay] [then] [50-100]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility [MRI][CAT][PET][All other Scans]	[[$[0-1,000] per scan copay] [then] [plan deductible] [then] [No charge]] [plan deductible] [then] [No charge] [[$[0-500] per scan copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] per scan copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-1,000] per scan deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-1,000] per scan deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
[[Habilitative Services] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [In-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined] [Out-of-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] for all therapies combined]	[Primary Care Physician] [[$[0-100] per office visit copay] [but not less than $[20-150]] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per office visit copay] [but not less than $[20-150]] [then] [50-100]%] [Specialty Care Physician] [[$0-$150] [per office visit copay] [but not less than $[20-150]] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-$150] per office visit copay] [but not less than $[20-150]] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [[plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Outpatient Short-Term Rehabilitative Therapy** [**and Chiropractic Services**][and Habilitative Services] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited] [including] [for][Physical], [Speech] [and][Occupational]Therapies for treatment of [Autism][and][developmental delays][and][learning disabilities] [(The limit is not applicable to mental health conditions.)]] [In-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] ~~]~~ [Out-of-Network [Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited]] [for all therapies combined] [(The limit is not applicable to mental health conditions.)]] ~~]~~ Includes: [Cardiac Rehab] [Physical Therapy] [Speech Therapy] [Hearing Therapy] [Occupational Therapy] [Pulmonary Rehab] [Cognitive Therapy] [Chiropractic Therapy (includes Chiropractors)] [Physical Therapy, Speech Therapy and Occupational Therapy will not be subject to a [Contract] [Calendar] year maximum for children under age 21 with a congenital or genetic birth defect (including autism)] [The age limit does not apply to treatment for autism.]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [**Note:** The Outpatient Short Term Rehab copay [does not apply to services provided as part of a Home Health Care visit] [applies, regardless of place of service, including the home].]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

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BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Outpatient Short-Term Rehabilitative Therapy**		
[[Physical Therapy] [Speech Therapy] [Hearing Therapy] [Occupational Therapy] [Pulmonary Rehab] [and] [Cognitive Therapy]] [[Contract] [Calendar] Year Maximum: [[20-Unlimited] [visits] [days]] [$1,000-Unlimited] [for all therapies combined]] [[20-Unlimited] [visits] [days]] [$[1,000-Unlimited] [for Physical, Speech and Occupational Therapies for treatment of [developmental delays][and][learning disabilities]] Physical Therapy, Speech Therapy and Occupational Therapy will not be subject to a [Contract] [Calendar] year maximum for children under age 21 with a congenital or genetic birth defect (including autism)	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
[**Outpatient Cardiac Rehabilitation** [Contract] [Calendar] Year Maximum: [36-Unlimited] days	[Specialty Care Physician] [[$[0-150] per office visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-$150] per office visit copay] [then] [50-100]%]	[In-Network coverage only] [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[[**Self-Referral**] **Chiropractic Care Services** [[Contract] [Calendar] Year Maximum: [12-Unlimited] [visits] [days] [visits or days] [consecutive days per condition] [$[500-Unlimited]] Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Home Health Care** [[Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary) [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]] [In-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (includes outpatient private nursing when approved as medically necessary) [Administration of [Medical Specialty Drugs-] [Medical Pharmaceuticals] is [40-Unlimited] [days] [visits] [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]] Out-of-Network [Contract] [Calendar] Year Maximum: [40-Unlimited] [days] [visits] (reduced by any In-Network [days] [visits]; includes outpatient private nursing when approved as medically necessary)] [Administration of [Medical Specialty Drugs] [Medical Pharmaceuticals] is [40-Unlimited] [days] [visits] [The limit is not applicable to Mental Health and Substance Use Disorder conditions.]]	[plan deductible] [then] [No charge] [[$[0-150]] [per visit copay] [per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150]] [per visit copay] [per day copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[**Hospice** Inpatient Services [180-Unlimited][days][visits][per Lifetime]	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Services (same coinsurance level as Home Health Care) [[3-Unlimited] [days][visits] per[Contract] [Calendar] Year	[plan deductible] [then] [No charge] [[$[0-150]] [per visit copay] [per day copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150]] [per visit copay] [per day copay] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Lifetime Maximum: $[5,000-Unlimited]]		
Bereavement Counseling Services Provided as part of Hospice Care		
Inpatient	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Outpatient	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Services Provided by Mental Health Professional	Covered under Mental Health benefit	[In-Network coverage only] [Covered under Mental Health benefit]
[Medical Specialty Drugs][Medical Pharmaceuticals]		
Inpatient Facility	[plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Physician's Office	[plan deductible] [then] 50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Home Care	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%]
Maternity Care Services		
Initial Visit to Confirm Pregnancy [**Note:** OB/GYN providers will be considered [either as] a [PCP or] Specialist [depending on how the provider contracts with Cigna] [on an In-Network basis.] [Out-of-Network OB/GYN providers will be considered a Specialist.]]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Delivery - Facility (Inpatient Hospital, Birthing Center)	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [[plan deductible] [then] [50-100]%]]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Abortion Includes [elective and] non-elective procedures		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[**Family Planning Services**		
[Physician's Office Visit (tests, counseling)] [Office Visits, Lab and Radiology Tests and Counseling] [Maximum: subject to plan's Preventive Care dollar maximum] [**Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.]	Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%
Surgical Sterilization Procedure for [Vasectomy][/][Tubal Ligation](excludes reversals):		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visits	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Infertility Treatment Testing and treatment for Infertility. **Note:** Medically Necessary treatment of an underlying medical condition is covered as any other illness under the plan.	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Infertility Treatment** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination [Services Not Covered include:] • In-vitro, GIFT, ZIFT, etc. [Surgical Treatment: Limited to procedures for the correction of infertility.]		
[Infertility Treatment Per Procedure Per Person Per Lifetime Maximums [GIFT] [ZIFT] [In Vitro]	$[500-100,000] $[500-100,000] $[500-100,000]	$[500-100,000] $[500-100,000] $[500-100,000]]
Physician's Office Visit (including Counseling) [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Surgical Procedure Copay] [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[[plan deductible] [then] [$[0-750] Surgical Copay]] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission][then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
[Lifetime Maximum: $[5,000-Unlimited] per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).]]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Organ Transplants** Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [100% at Lifesource center, otherwise] [$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-4,500] per admission copay] [then] [100% at Lifesource center, otherwise] [plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [100% at Lifesource center , otherwise] [plan deductible] [then] [50-100]%] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]% up to transplant maximum] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]% up to transplant maximum] [[plan deductible] [then] [30-80]% up to transplant maximum]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [100% at Lifesource center , otherwise] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]% [up to specific organ transplant maximum:] Heart - $[25,000-Unlimited] Liver - $[25,000-Unlimited] Bone Marrow -$[25,000-Unlimited] Heart/Lung - $[25,000-Unlimited] Lung - $[25,000-Unlimited] Pancreas - $[25,000-Unlimited] Kidney - $[25,000-Unlimited] Kidney/Pancreas - $[25,000-Unlimited]]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[Lifetime] Travel Maximum: $[0-Unlimited] per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only]
[**Durable Medical Equipment (including External Prosthetic Appliances)** [In-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[500-Unlimited]] [[Contract] [Calendar] Year Maximum: [$500-Unlimited]] [In-Network Lifetime Maximum: $[3,000-Unlimited]] [Out-of-Network Lifetime Maximum: $[3,000-Unlimited]] [Lifetime Maximum: $[3,000-Unlimited]] [**Note:** Services do accumulate to the plan's out-of-pocket maximum.]	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Durable Medical Equipment** [In-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] Out-of-Network [Contract] [Calendar] Year Maximum: $[700-Unlimited]] [[Contract] [Calendar] Year Maximum: $[700-Unlimited]] [**Note:** Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Nutritional Evaluation Calendar Year Maximum: 3 visits per person; however, the 3 visit limit will not apply to treatment of diabetes [and/or to Mental Health and Substance Use Disorder conditions] Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the $[0-100] PCP or $[0-150] Specialist per office visit copay [plan deductible] [then] [50-100]%	[plan deductible] [then] [50-100]%
[**External Prosthetic Appliances** [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [**Note:** [The EPA deductible will not accumulate to the plan Out-of-Pocket maximum.] Service maximums do not cross accumulate between In-Network and Out-of-Network services. Services do accumulate to the plan's Lifetime maximum.]	[[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [No charge]] [[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-500] EPA deductible per] [Contract] [Calendar]]Year] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-500] EPA deductible per] [Contract] [Calendar] [Year] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-500] EPA deductible per] [Contract] [Calendar]]Year] [then] [30-80]%] [30-80]% [then] [plan deductible]
[Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
TMJ Surgical and Non-surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible][then] [30-80]%
[**Surgical and**] **Non-surgical TMJ Services** [(surgical services will be covered same as any other illness)] [Lifetime Maximum: $[600-Unlimited]] [[Calendar] [Contract] Year Maximum: $1,000-Unlimited]]		

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Obesity/Bariatric Surgery** **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Facility	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Physician's Services	[plan deductible] [then] [No charge] [50-100]% []	[In-Network coverage only] [plan deductible] [then] [30-80]%
Lifetime Maximum: $[8,000-Unlimited] Coinsurance charges for obesity surgery will not accumulate to the plan Out-of-Pocket maximum.]		
[Dialysis Calendar Year Maximum		Maximum applies regardless of place of service $[10,000-50,000]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Physician's Office visit [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%]

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Inpatient Hospital - Facility Services	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room [**Note:** The [facility copay] [facility deductible] [facility copay or facility deductible] will apply as long as services billed include one or more of the facility room charges listed above.] [**Note:** Non-surgical treatment procedures are not subject to the [facility copay] [facility deductible] [facility copay or facility deductible].]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[In-Network coverage only] [[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%
Home Setting	[plan deductible] [then] [50-100]%	[In-Network coverage only] [plan deductible] [then] [30-80]%
Hearing Exam Includes [adult hearing exams], [diagnosis][testing and fitting of hearing aid devices]	[Not Covered] [Covered the same as Specialist Office Visit]	[Not Covered] [Covered the same as Specialist Office Visit]
[Hearing Aids [1-Unlimited][Per ear][Per pair]Maximum per individual [every [1-5] years][per Lifetime] [0-115 years old] [$[500-50,000]]	[Not Covered] [plan deductible] [then] [50-100]%	[Not Covered] [plan deductible] [then] [30-80]%

BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Acupuncture** Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a [5-Unlimited] [day] [visit] maximum per person per year	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [plan deductible] [then] [30-80]%
Diabetic Equipment Contract][Calendar] Year Maximum: Unlimited	[No charge] [50-100]% [after plan deductible]	[30-80]% after plan deductible]
Include for plans with no pharmacy benefit [[Diabetic Medications]	[$10] copay][	[30-80]% after plan deductible]]
[Gender Reassignment Surgery [$75,000 Lifetime Maximum across all transgender services]	[[$[0-150][then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] [then] [50-100]%]	[plan deductible] [then] [30-80]%]
[**Routine Foot Disorders**	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.]

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BENEFIT HIGHLIGHTS	IN-NETWORK	[OUT-OF-NETWORK]
[**Routine Foot Disorders** [Visit(s) 1-10] [Visits 2-Unlimited] [Visits 2- Unlimited] Physician's Office Visit [[Contract] [Calendar] Year Maximum: $[1,000-Unlimited]] [In-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited] Out-of-Network [Contract] [Calendar] Year Maximum: $[1,000-Unlimited]]	[Primary Care Physician] [[$[0-100] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-100] per visit copay] [then] [50-100]%] [Specialty Care Physician] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[In-Network coverage only] [Primary Care Physician] [plan deductible] [then] [30-80]% [Specialty Care Physician] [plan deductible] [then] [30-80]%-]
[**Treatment Resulting From Life Threatening Emergencies** Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized [and will not count toward any plan limits that are shown in the Schedule for mental health and substance use disorder services including in-hospital services]. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.]		
For plans subject to MHSUD Parity		

Inpatient Includes Acute Inpatient and Residential Treatment Unlimited maximum per Calendar year	[[[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Outpatient		
Outpatient – Office Visits Includes individual, family [and group] psychotherapy; medication management, [Behavioral Telehealth] etc. Unlimited maximum per Calendar year [Behavioral Telehealth - Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%]	[plan deductible] [then] [30-80]%]
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient services, [group psychotherapy] [Behavioral Telehealth] etc.) Unlimited maximum per Calendar year] [Behavioral Telehealth - Outpatient - Office Visits]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

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~~[Substance Use Disorder~~

[Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Unlimited maximum per Calendar year	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%
Outpatient **Outpatient – Office Visits** Includes individual, family [and group] psychotherapy, medication management, [Behavioral Telehealth] etc. Unlimited maximum per Calendar year [Behavioral Telehealth - Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]% [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services [group psychotherapy], [Behavioral Telehealth] etc. [Behavioral Telehealth - Outpatient - Office Visits] Unlimited maximum per	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

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Option for plans exempt from MHPA [**Mental Health**		
Inpatient	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient (Includes Individual, Group and Intensive Outpatient [and Behavioral Telehealth]) Physician's Office Visit] [Behavioral Telehealth] - Outpatient - Office Visits]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%]	[plan deductible] [then] [30-80]% [plan deductible] [then] [30-80]%]
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

[Outpatient Includes Individual, Group and Intensive Outpatient [and Behavioral Telehealth] Applies to Physician's Office and Outpatient Facility] [Behavioral Telehealth- Outpatient -– All Other Services] [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility deductible.]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then][30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [plan [then][30-80]%]] [plan deductible] [then] [30-80]%

Option for plans not subject to MHPA [**Substance Use Disorder**]		
Inpatient	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

[**Outpatient (Includes Individual and Intensive Outpatient**[and Behavioral Telehealth]) Physician's Office Visit]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]% [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
[Behavioral Telehealth– Outpatient - Office Visits]		
[Outpatient Facility [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility copay or the outpatient facility deductible.]	[[$[0-2,250] per visit copay] [then] [plan deductible] [then] [No charge]] [[$[0-2,250] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-2,250] per visit deductible] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-4,500] per visit deductible] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-4,500] per visit deductible] [then] [30-80]%] [plan deductible] [then] [30-80]%

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[Outpatient Includes Individual and Intensive Outpatient Applies to Physician's Office and Outpatient Facility[and Behavioral Telehealth]] [Behavioral Telehealth-Outpatient - – All Other Services] [**Note:** Non-surgical treatment procedures are not subject to the outpatient facility deductible.]	[[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%

Option for plans not su bject to MHPA [**Mental Health**		
Inpatient [Contract] [Calendar] Year Maximum: [60-Unlimited] days Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 [Residential: based on a ratio of 2:1] [Residential for Substance Use Disorder: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30--80]%
Outpatient	[Visits [1-40]:] [75-100%] after plan deductible [Visits [41-Unlimited]:] [60-100]%][after plan deductible]	[Visits [1-40]:] [75-100%] after plan deductible [Visits [41-Unlimited]:] [60-100]%][after plan deductible]

Outpatient Group Therapy [(One group therapy session equals one individual therapy session)] [[Contract] [Calendar] Year Maximum: [40-Unlimited] visits]	[$[0-150] per-visit copay] [then] [No charge]] [[$[0-150] per visit copay] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-150] per visit copay] [then] [50-100]%] [plan deductible] [then] [50-100]%	[plan deductible] [then] [30-80]%
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Based on a ratio of 1:1	[[$[0-2,500] per program copay] [then] [50-100]%]	[plan deductible] [then] [50-100]%

Option of Plan not subject to MHPA [**Substance Use Disorder**]		
Inpatient [Contract] [Calendar] Year Maximum: [60-Unlimited] days Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 [Residential: based on a ratio of 2:1] [Residential for Substance Use Disorder: based on a ratio of 2:1 Residential for Mental Health: Not Covered]	[[$[0-4,500] per admission copay] [then] [plan deductible] [then] [No charge]] [[$[0-4,500] per admission copay] [then] [plan deductible] [then] [50-100]%] [[$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [plan deductible] [then] [50-100]%] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [No charge]] [[plan deductible] [then] [$[0-4,500] per admission copay] [then] [50-100]%] [[plan deductible] [then] [$[0-1,500] per day copay] [up to [3-Unlimited] copays] [per admission] [then] [50-100]%] [plan deductible] [then] [50-100]%]	[[$[0-9,000] per admission deductible] [then] [plan deductible] [then] [30-80]%] [[$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [plan deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-9,000] per admission deductible] [then] [30-80]%] [[plan deductible] [then] [$[0-3,000] per day deductible] [up to [3-Unlimited] deductibles] [per admission] [then] [30-80]%] [plan deductible] [then] [30-80]%

Outpatient [Contract] [Calendar] Year Detoxification Maximum: [12-Unlimited] visits	[[Visits [1-40]:] [75-100%]] [[Visits [41-Unlimited]:] [[60-100%] per visit copay	[[Visits [1-40]:] [75-100%]] [[Visits [41-Unlimited]:] [60-100%] per visit copay]
Intensive Outpatient [Contract] [Calendar] Year Maximum: up to [3-Unlimited] programs Maximum: Each visit provided as part of a program accumulates to the Outpatient Substance Use Disorder benefit maximum on a 1:1 ratio basis with Outpatient Substance Use Disorder visits.	[[$[0-2,500] per program copay] [then] [50-100]%]	[plan deductible] [then] [50-100]%

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- [care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. [For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered [Service][Expense] (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered [Service][Expense], or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna.][[This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network~~Providers who have agreed to charge you or charged you at an In-Network~~ benefits level or some other benefits level not otherwise applicable to the services received.] [Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Co-insurance you are required to pay.]
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, S~~s~~ubstance U~~u~~se D~~d~~isorder or other health care technologies, supplies,

treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Ssickness for which its use is proposed;
- ~~not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;~~
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem

- The following services are excluded from coverage regardless of clinical indications: [Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Orthognathic Surgeries; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.]
- [[surgical] or [nonsurgical] treatment of TMJ disorders.]
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted [wisdom] tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth)..
- [for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity;

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and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.]

- [medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.]
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- [infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of sperm, eggs or embryos are also excluded from coverage.]
- [reversal of male or female voluntary sterilization procedures.]
- any [medications, drugs,] services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction
- [medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.]
- ~~[intensive behavioral interventions, including but not limited to Applied Behavior Analysis (ABA); tuition for schools, facilities, or programs that render these therapies or interventions;]~~
- ~~[non-medical counseling or ancillary services including but not limited to] vocational rehabilitation, employment counseling, return-to-work services, work hardening programs, back school, and driving safety and services.~~
- ~~biofeedback, neurofeedback, hypnosis, sleep therapy, behavioral training.~~
- ~~[services or therapies that are primarily intended as training or education.]~~
- ~~[non-medical ancillary services [for] [learning disabilities], [developmental delays], [autism], or [intellectual disabilities].]~~
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- ~~~~
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

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- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- [hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.]
- [aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.]
- [aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.]
- corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of corrective lenses and associated services following treatment of keratoconus or cataract surgery.
- [Routine refractions,] eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- [treatment by acupuncture.]

- all noninjectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

~~- all noninjectable prescription drugs, [injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs,] nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.~~

- [routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.]
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

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- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae [except for infant formula needed for the treatment of inborn errors of metabolism].
- [medical treatment for a person age 65 or older, who is covered under this plan as a retiree, [or their Dependent,] when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.]
- [medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.]
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- [telephone, e-mail, and i~~I~~nternet consultations.]
- [telephone, e-mail, and i~~I~~nternet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.]
- [charges for Care Management and Care Coordination Services except when provided by designated health care professionals who participate in specific collaborative arrangements.]
- [charges for the delivery of [behavioral] [and] [medical] [and] [health][-related] services via telecommunications technologies, including telephone and internet [unless in a geo-remote area] [and] [or] [unless provided as specifically described under Covered Expenses.]]
- massage therapy.
- [abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.]
- [certain Medical Pharmaceuticals that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Medical Pharmaceutical(s) and is administered in connection with a covered service rendered in an [inpatient], [outpatient], [Physician's office] or [home health care] setting. Such determinations may be made periodically, and benefits for a Medical Pharmaceutical that was previously excluded under this provision may be reinstated at any time.]
-

General Limitations

No payment will be made for expenses incurred for you [or any one of your Dependents]:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you [or any one of your Dependents] is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- [to the extent that they are more than Maximum Reimbursable Charges.]
- [to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received out of network (for example, emergency care).]
- [for in-network only medical plans, to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received out of network (for example, emergency care). For other than in-network only medical plans, to the extent that they are more than Maximum Reimbursable Charges.]
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family [or your Dependent's Family].
- expenses incurred outside the United States other than expenses for M~~m~~edically N~~n~~ecessary urgent or emergent care while temporarily traveling abroad.]

Karen Montanaro
Compliance Manager
Cigna Legal

November 4, 2016

Routing B6-LPA
900 Cottage Grove Road
Hartford, CT 06152-1038
Telephone 860.226.5631
Karen.montanaro@cigna.com

Re: Cigna Health and Life Insurance Company
NAIC Company ID#: 67369
NAIC Group #: 901
FEIN: 59-1031071
Group Accident and Health Insurance
Policy/Certificate Series HP/HC
Certificate Insert Page: HC-SOC567 et al

Dear Sir or Madame:
We are submitting for your approval the above-referenced Group Accident and Health certificate insert pages to be used with our combined Policy/Certificate Document previously approved by your Department on 08/09/2010 in SERFF filing CCGH-126618547.

We are filing certificate insert pages which include:

- Pharmacy Schedule, Benefit Provisions, Important Information Provisions and Definitions,
- Prior Authorization
- Medical Covered Expense
- Definition of Medically Necessary,
- Medical Benefit Schedule,
- Exclusions,
- Coordination of Benefits,
- Subrogation,
- Payment of Benefits,
- Appointment of Authorized Representative and
- Definition of Dependent.

We consider any bracketed areas to be variable as shown. Please find the enclosed Description of Variable Material. A Rate Memorandum is included. A corresponding rate filing was sent to your Department on 10-03-2016 and approved on 10-18-16 under SERFF CCGP-130666805. This submission does not replace any certificate insert pages on file with your Department.

We have attached redlines showing changes to previously approved pages under the Supporting Documentation tab.

Thank you very much for your attention to this submission. If you have any questions or concerns, you can contact me directly at 860.226.5631. I can also be reached via e-mail at karen.montanaro@cigna.com.

Sincerely,

Karen Montanaro